Donna Lakes, L.L.C.- Energy Work Client Information Form

Name: _____ Date of Birth:_____

Address:_____

City:_____ State: _____ Zip: _____

Phone: Home : ( ) _____ Work/Cell: ( ) _____

e-mail: _____

Occupation: _____ Employer: _____

Spouse's name: _____ Occupation: _____

How did you hear about Donna Lakes? _____

Physician: _____ Medications: _____

In Case of Emergency: _____ Phone: ( ) _____

Reason for Appointment: _____

Comments: _____

Illness/ Conditions: _____

Please Read Carefully Before Signing

I understand that the Energy session/healing I receive is provided for the basic purpose of information, relaxation and relief of stress.
If I experience any pain or discomfort during the session I will immediately inform the practitioner. I further understand that any work or information given by a Donna Lakes representative should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.
I understand that the therapists/body workers are not qualified to perform any spinal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session(s) should be construed as such. Because energy work is contradicted under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to my medical profile and understand that there shall be no liability on the practitioners part should I forget to do so.
I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Donna Lakes may not be held liable for any claims of injury or harm, mental, emotional or physical.

I acknowledge that if I fail to cancel my appointment 24 hours before my scheduled time, I am responsible for payment of the missed appointment.

_____ _____

Client Signature Date Practitioner Signature Date