

Client Information

Today's Date _____

Name _____

If under 18 years of age Name of Parent/Guardian _____

Current Address _____

City _____ State _____ Zip _____

Phones - Cell _____ Home _____

Work _____ E-mail address _____

Date of Birth _____ Marital Status _____ If Divorced, When _____

If Separated, When _____ Number of Children _____ Ages _____

Profession _____

Employer _____

Status of Physical Health _____

Are you currently under psychiatric care or in psychotherapy? ___ Yes ___ No

If yes, please list name of health care practitioner and describe _____

Have you been in therapy or had psychiatric treatment in the past? ___ Yes ___ No

If yes, please describe _____

Are you currently on any medication(s) for your physical or mental health? If yes, please describe _____

Please describe your spiritual beliefs. Which statement(s) best describe you?

_____ I believe in God or a universal Spirit

_____ I am not religious but I am spiritual

_____ I am both religious and spiritual

_____ I am not sure if there is a God or universal Spirit

_____ I do not believe in God or a Universal Spirit

Comments about your faith or belief (optional) _____

Please describe what you would like to gain from our work together _____

Is there anything else you would like for me to know? _____

Whom may I thank for your visit? _____

Client Agreement

Pastoral medical services are distinctly different from conventional medical services and focus on improving and recovering health, not on diagnosing or treating any symptoms you may have. It is your responsibility to seek conventional medical advice and/or assistance if you are ill or suffering symptoms that concern you and are beyond the scope of Pastoral health services. The practitioner you are providing information to in this form is an authorized ministerial health care practitioner through the Pastoral Medical Association, a Private Ecclesiastical Jurisdiction. Admission, services and agreements between you and the practitioner are regulated by the PMA Informed Consent and Request for Admission and Services from (ICRAS) and in-part provide that all information you provide in whatever form is “confessional” (confidential) and cannot therefore be released to any individual or agency outside the PMA jurisdiction except under specific conditions and at the sole discretion of the PMA authorized practitioner.

By signing below you agree to the following: I understand that Emotional Freedom Techniques (EFT) is an experimental technique and is not meant to replace standard medical care. I understand that Kay Christopher does not recommend that I stop using any prescribed medicine or other kind of therapy that I may be using without consulting the appropriate licensed health care provider.

I understand that fees are \$135 per hour. Sessions over an hour are charged on a prorated basis in 15 minute segments. I understand that payment is due at the time of my appointment unless other arrangements have been made in advance.

I understand that if I need to change my appointment time I am asked to give 48-hours notice. If less than 24-hour notice is given I will be charged the full fee for the session.

Print Name

Date

Sign Name

IF YOU ARE A PARENT OR GUARDIAN PLEASE COMPLETE THE INFORMATION BELOW

Child's or Charge's Printed Name

Date

Authorized Parent or Guardian Name

Signature