ENERGETICS SYSTEMS™ Treatment

Client Health Information

Please complete form – All information will remain confidential

Last Name:	First Name:	Middle Initial:
Street Address:	City:	State:	Zip Code:
Primary Phone #: __Home/ __cell/ __work	Secondary Phone #: __Home/ __cell/ __work	Email: (contact purposes only)
Profession:		

Birth date:	Sex: Male or Female	
Do you have a pacemaker or other electrical monitoring device within the body?	Yes	No
Do you have any artificial organs, or have you received an organ transplant?	Yes	No
Are you pregnant or nursing?	Yes	No
Are you on any medication medicine?	Yes	No
If yes, what kind of medication?		
How did you hear about the Energetics Systems Treatment?		

I acknowledge that by participating in a Energetics Systems Treatment, I understand that no medical diagnosis can be made. I understand that the Energetics Systems Treatment I am receiving is not a substitute for normal medical care, and I should continue any present medical treatment and consult my regular medical doctor for treatment of any new or old illnesses. I further take responsibility for my own health and well-being. **Initials:**_____

Signature:_____ Date: _____

ENERGETICS SYSTEMS™ Treatment Plan

Name:

Cycle # (i.e., 1st or 2nd, etc.)	Cycle Start Date:

Treatment Date		Notes: (Comments during, after or/and between baths)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		

REST for 21 Days……

Start Date for Next Cycle:_____