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| Fly Again Acupuncture, PLLC Melissa Thomas  | **518-855-1455** |

 70 Main Street, Greenwich | 61 Rowland Street, Suite 221 Ballston Spa

The Emotion Code Intake Form

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| Today's Date: |  |
| Full Name:  | Phone Number: |
| Date of Birth: | Street Address: |
| Email:  | City, State, Zip Code: |
|  |  |
| Emergency Contact Name: | Primary Physician:  |
| Phone Number: | Phone Number: |
| Occupation / Employer / School |  |
| How did you hear about us?  |  |
|  |  |
| Preferred Session Type: □ In Person □ Phone □ Proxy (long distance treatment) |
| Do you have a pace maker?  |
|  |
| PRIMARY FOCUSPlease describe the TOP THREE AREAS you would like to try and improve using The Emotion Code. |
| 1.  |  |
|  |  |
| When did it begin? |  |
| 2.  |  |
|  |  |
| When did it begin? |  |
| 3.  |  |
|  |  |
| When did it begin? |  |
|  |  |
| ALLERGIES/NUTRITIONPlease list any known allergies or food sensitivities. If none, please indicate: |
| Do you follow any special diets? |
| Do you experience food cravings? |
| Do you experience emotional eating? |
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| PERSONAL HABITSPlease indicate how often you use the following substances and if you would like to change your frequency of use. |
| Caffeine (Coffee, soda, tea) | # \_\_\_\_\_\_\_ Times per Day/Week/Month | Do you want to change that amount Y / N |
| Alcohol | # \_\_\_\_\_\_\_ Times per Day/Week/Month | Do you want to change that amount Y / N |
| Cigarettes/tobacco | # \_\_\_\_\_\_\_ Times per Day/Week/Month | Do you want to change that amount Y / N |
| Marijuana | # \_\_\_\_\_\_\_ Times per Day/Week/Month | Do you want to change that amount Y / N |
| Stimulants: Cocaine, Crack, Speed, Methamphetamines | # \_\_\_\_\_\_\_ Times per Day/Week/Month | Do you want to change that amount Y / N |
| Opioids: Heroin, Methadone, Morphine, Oxycodone, Fentanyl | # \_\_\_\_\_\_\_ Times per Day/Week/Month | Prescription: Y / NDo you want to change that amount Y / N |
| Other­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | # \_\_\_\_\_\_\_ Times per Day/Week/Month | Do you want to change that amount Y / N |
|  |  |  |
| Do you exercise regularly? |
| Do you have any habits that you would like to change? |
|  |
| SURGERY/SIGNIFICANT INJURY HISTORY |
| Please list any past surgeries, injuries, or hospitalizations: |
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|  |
|  |
|  |
|  |
| EMOTIONS(Please check those which dominate your experience) |
| □ Anger□ Irritability□ Anxiety□ Worry□ Obsessive thinking | □ Sadness□ Grief□ Depression□ Joy□ Fear | □ Timidness/shyness□ Indecisiveness□ Easily stressed□ Thoughts of suicide□ Treated for emotional health |
|  |  |  |
| Is there anything else you would like us to know? |
|  |
|  |
| FEMALE PATIENTS |
| Are you, or could you be pregnant? □ Yes □ No |
| Have you had any difficulties or distress during or after pregnancy? |
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Consent to The Emotion Code Treatment

By signing this form I consent to The Emotion Code energy work treatments at Fly Again Acupuncture and certify that I understand the following statements.

I understand that these sessions are not intended to diagnose, treat, or cure any medical condition. There is no guarantee that Emotion Code sessions will improve any specific condition or complaint. I understand that that Melissa Thomas CECP is not a licensed medical practitioner. I understand that Emotion Code sessions are not a substitute for professional psychological or medical care. I understand that around 20% of people experience vivid dreams, fatigue or moodiness for up to 48 hours after a session as their subconscious processes the negative energy.

Except in the case of gross negligence or malpractice, I or my representatives agree to fully release and hold harmless Melissa Thomas and Fly Again Acupuncture PLLC from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my sessions.

I understand and agree to all the above statements and wish to proceed with The Emotion Code energy work sessions.

Client’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_