Reference #_____ (For Office Use Only) Date_____

CONSENT FOR TREATMENT FORM

Name_____ Email _____

Mailing Address_____

Phone: Cell _____ Home_____ Referred By_____

Emergency Contact (name/phone) _____

The purpose of this Consent Form is to clarify the scope of the treatment to be provided in our process as Energy Healer and Client.

In my role as Energy Healer, I, Aluvia Marlene Astrid will foster your healing process through the use of energy healing techniques which may or may not require that I lay my hands on your physical body. My intention is to engage with you in your healing process in a way that facilitates your ability to self-heal and heightens your awareness of both your current condition and healing process. This is accomplished through direct work with your Energy Field, as well as through the exploration of your health history, diet, exercise, childhood, life stresses, and beliefs which may impact your Physical, Emotional, Mental and Spiritual well-being.

Since I am not a Physician or Psychologist, I recommend that you have these professionals enlisted as part of your Healing Team. I do not diagnose illness or disease or prescribe medications. I encourage you to share our work with members of your Healing Team and am available to discuss our work with them as well, based on your signed consent to Release Information.

I may discuss our healing work with peers or professionals to foster my professional development, but you will remain anonymous in these discussions. I am not aware of any negative side affects of the treatment I provide.

Client Acknowledgement and Release:

I, _____, hereby acknowledge that I have read the above conditions of receiving treatment from Aluvia Marlene Astrid, and that I freely choose to receive these treatments. I assume all risks and responsibilities for the affects of the treatments received and release Aluvia Marlene Astrid from any claims of malpractice or harm.

Client Signature _____ Dated _____

Print Client Name _____

Accepted by Aluvia Marlene Astrid

Signature_____ Dated_____

Reference #_____ (For Office Use Only) Date_____

Your Healing Journey

You can use the reverse side of this form for explanations or additional comments.

D.O.B._____ Country of Birth _____ # Siblings_____ # Children_____

Relationship Status_____ Occupation(s)_____

Please describe injuries and surgeries (with dates)

Please describe any traumatic, life-threatening or life-changing events (Physical, Emotional, Mental) with dates

What is your intention for your healing now and in the future?

What would you like to create in your life that is not yet manifest?

Are there any relationships that you would like to create or improve?

Anything else you would like me to know about you?

Reference #_____ (For Office Use Only) Date_____

Your Healing Journey

You can use the reverse side of this form for explanations or additional comments.

YOUR HEALING TEAM: (Name, Specialty, Phone)

Physicians _____

Specialists _____

Therapists _____

Alternative Healers _____

Current/Previous Treatments_____

Current Medications_____

Current Therapies/Supplements_____

Height_____ Weight_____ Eating Habits/Diet_____
Daily Intake: Water_____Caffeine_____Alcohol_____ Cigarette/Tobacco_____
Vision:_____ Eye Glasses/Contacts?_____ Hearing_____ Taste_____ Smell_____
Exercise Routine_____

Please mark/add the following areas with: "C: for current, "P" for past, and "CH" for Chronic.

Emotional/Psych	**Endocrine**	**E N T**	**Digestion**
Depression	Adrenal Insuf.	Earaches(chronic)	Diarrhea
Eating Disorder	Pituitary Dysf.	Sinus & Throat	Constipation
Mood Swings	Hyperthyroid	Jaw Pain	Gastritis
Substance Abuse:	Hypothyroid	**Cardiovascular**	Diabetes
Auto-immune	**Neurological**	Angina	Hypoglycemia
AIDS/HIV	Epilepsy	Heart Attack	Hyperglycemia
Allergies	Dizziness	Hypertension	Jaundice
Cancer (type)	Insomnia	Stroke	Ulcers
Fatigue	Migraines	**Respiratory**	**Urinary**
Fever (chronic)	**Musculo-Skeletal**	Bronchitis	Bladder Infection
Fibromyalgia	Arthritis/Gout	Emphysema	Kidney Stones
Fungal Infections:	Back Pain	Pneumonia	**Reproductive**
Herpes:	Carpal Tunnel	Tuberculosis	STD
Mononucleosis	Skin Disorder:	**Organs**	Endometriosis
		Liver Disorder	Pregnancies (#)
		Hepatitis	Miscarriage(#)
		Colon	Abortion(#)