# Soaring Heart Medicine

110 E Main st. Jacksonville, OR 97501
541.292.1209 www.soaringheartmedicine.com

Name:____________________________________________Date__________________________

Address:___________________________________City/State________________Zip:________

Phone:_________________________Email:__________________________________________

DOB:______________Name as it appears on birth certificate (for Numerology readings): _____

_______________________________________________________________________________

Who may I thank for referring you:______________________________________________

Please take some time to carefully read the following and explain as needed. Your privacy is important and your information will be kept confidential. Please share only to the degree that you are comfortable with. Mindful consideration will help you to connect with and understand more about your state-of-being at this point in time.

What areas of life would you like to change or improve:_________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Have you experienced any of these holistic therapies before:______________________________

__massage therapy __polarity __reflexology __meditation __ThetaHealing __EFT

__energy medicine __reiki __coaching __NLP __sound therapy __cranial sacral __psych-K

__crystal/gemstone therapy __essential oils/aromatherapy __access bars __TRE __belief-work

__spiritual guidance/direction __numerology __divination cards/tarot __astrology

__sacred plant medicine __healing ceremony __shamanic practices __faith healing

Others?_________________________________________________________________

I am most interested in experiencing: (or circle from above options)__________________

_______________________________________________________________________

Do you have any allergies or sensitivities to oils, lotions, scents, foods, medicines, plants, etc?

Please list:_____________________________________________________________

Do you frequently suffer from stress? __yes__no Average stress range? 1 2 3 4 5 6 7 8 9 10

What do you feel is the primary source of your stress? ______________________________

______________________________________________________________________________

______________________________________________________________________________

What physical, emotional or spiritual feelings would you like to experience more of:__________________________________________________________________________

______________________________________________________________________________

What medications are you currently taking and for what purpose? (include drugs, herbs, oils, vitamins, prescriptions etc): ___________________________________________________.

______________________________________________________________________________

______________________________________________________________________________

Self-care is important. What are your current daily practices, routines, rituals and practices (if any) that help you feel better: _________________________________________

______________________________________________________________________________

______________________________________________________________________________

Are you under the care of a physician? If so, for what reason?________________________

______________________________________________________________________________

______________________________________________________________________________

About how much per day do you use the following?

Coffee, tea, soft drinks (caffeine) ___________ Alcohol (in what form?) _________________

cigarettes, cigars, tobacco_________or vape__________ THC or CBD (circle)____________

Other drugs?___________________________________________________________________

How many hours of television per day?_____________________________________________

How many hours of other screen time?_____________________________________________

How often do you exercise or engage in physical activity? What kind?_________________

______________________________________________________________________________

How much water do you drink per day?____________________________________________

How many hours of sleep?_________________________ Do you wake feeling rested? Y/N

How many servings of fruits and vegetables per day?________________________________

**Physical -** please check all that apply. If this has occurred in your family of origin check the O

___any contagious disease? explain_________________

___arthritis O

___cardiac or circulatory problems O

___diabetes O

___low blood pressure O

___high blood pressure O

___frequent headaches

___currently pregnant or breastfeeding

___problems with fertility/conceiving O

___miscarriages O how many?_____

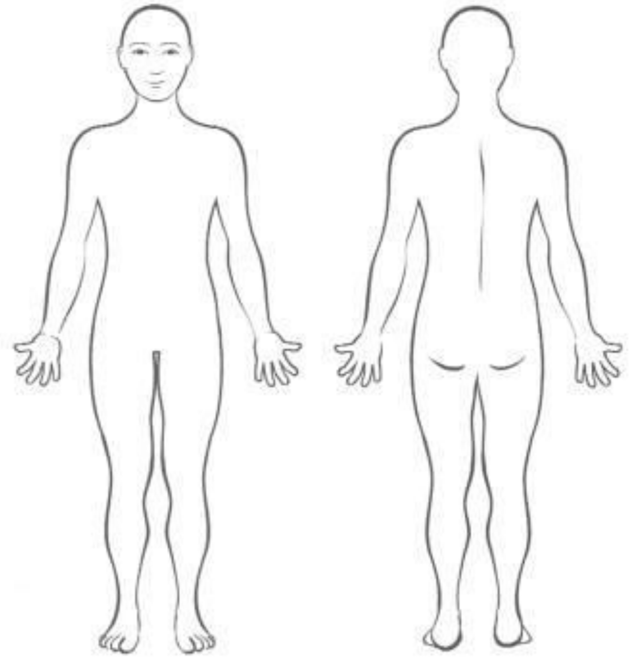
___epilepsy O

___cancer or receiving treatment for cancer O
explain__________________________________________

___physical pains O

explain or mark on above diagram_____________________

__other disease or disorder O explain:__________________



**Emotional/Spiritual -** please check all that apply. If this has occurred in your family of origin check the O

___anger/irritability O

___difficulty with focus/ concentration O

___difficulty forgiving yourself or others O

___feelings of guilt or remorse O

___insomnia or difficulty falling asleep/staying asleep O

___lack of self confidence O

___lack of trust O

___sadness/loss/grief O

___feelings of depression O

___high anxiety O

___low self-confidence/self-worth O

___suicidal thoughts O attempts?_______ O

___hearing voices O

___hallucinations/ visions O

___kundalini awakening or spiritual awakening O

___feelings of being possessed or having attached entity/energy that is not yours O

___feelings of being cursed or vexed O

___feeling ungrounded/ inability to stay “in your body” O

Do you know of or have any awareness of difficulty or trauma during your own birth or leading up to it?
explain________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you experienced any physical or emotional trauma that stands out to you?________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Do you feel like you have the emotional/spiritual support that you need?(from friends and family or elsewhere?)______________________________________________________
________________________________________________________________________

Would you say that you have a spiritual relationship with or connection to God/Creator/Source/Great Mystery? __yes ___no What name/s are you most comfortable with?_____

examples (circle): God, Goddess, Creator, Allah, Source, Energy, Love, Adonai, the Universe, Creation, the Infinite, the Divine, Great Spirit, Mystery, Consciousness, Father, Mother, All-that-Is, the One, Ultimate Reality, etc

I consider myself atheist ___yes ___no

I consider myself religious ___yes ___no Specific religion?_________________________

I consider myself spiritual/non-religious ___yes ___no

I am unsure about my spiritual and religious beliefs___yes___no

What does your religious or spiritual practice consist of?_____________________________
________________________________________________________________________
________________________________________________________________________

Do you have any other comments or concerns that have not been covered?_____________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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Please Read and Sign:

I have stated all my known conditions and have answered all questions honestly. I will inform Colbee of any changes in my status or condition. I understand that Colbee does not diagnose, prevent or treat illness, disease or any other physical or mental condition.

I understand that this session is not a substitute for medical treatments and/or diagnosis, and it is recommended that I see a qualified professional for any physical or mental condition that I may have. I understand this treatment is not a substitute for medical care. I understand that I will not be asked to or encouraged to discontinue any treatment plans or medications that have been prescribed by a medical doctor. Soaring Heart Medicine's services are meant to complement conventional medicine and personal self-care. I understand that some medical conditions may be contraindicated for certain types of treatment. A doctor's note may be needed in certain instances.

I acknowledge my active role in my holistic healing plan. I understand that in my sessions my comfort level will always come first and that I will communicate when I am physically or emotionally uncomfortable. I, or the practitioner, may request the session to stop or change for any reason.

I agree to payment at the time of service by cash or check unless otherwise discussed and arranged. A $25 fee will apply to all returned NSF checks. I am aware there is a 24 hour cancellation policy and I may be billed for up to 50% of the session fee if I do not provide sufficient notice when cancelling or changing my appointment.

Client Signature_______________________________________________Date________________

Consent for a session with a minor- By my signature below, I hereby authorize Colbee McManamon to administer energy medicine techniques to my child or dependent as she deems necessary.

Signature of Parent or Guardian: _____________________________________Date____________