**Weaving Energy, LLC**

 Rosemary Thompson

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**Intake Form**

**Contact Information**

Date:

Name:

Address:

City, State, Zip Code:

Phone Numbers/Phone Type:

Email/Permission to add to email list?:

**Personal Information**

Date of Birth/Age:

Occupation/How long?:

**Additional Information**

Past Occupations:

List prescription medications taken, indicating frequency and for what symptoms:

List vitamins, supplements, over the counter medications, topical products, herbs, etc. used:

Current food allergies or dietary conditions you notice?

Current stresses, life challenges or emotional pain for you?

Past traumas, accidents, injuries, surgeries, stresses, life challenges (including childhood)?

List other health/natural health resources you use/have used:

What do you know about homeopathy & neurofeedback?

**Family History**

Please share anything that you feel is relevant for you and your extended family.  Please also include if you have had childhood or adult vaccines and any patterns of disease, addiction, mental health concerns and abuse for you and/or your extended family: