



Minerva Educational and Wellness Treatment Center

Wellness Counseling, Treatments, Educational Programs and Products that provide Healthy Healing for Healthy Living

CONSENT FOR TREATMENT

Therapeutic Touch, Healing Touch, Reiki, Flower Essences, Aromatherapy, Integrated Energy Therapy

Therapeutic Touch, Healing Touch, Reiki, Flower Essences, Aromatherapy or Integrated Energy Therapy is not a substitute for regular medical checkups. Detecting infections, tumors, fractures or other hidden conditions is not within the scope of this practice.

It remains the patient's responsibility to seek standard medical treatment if symptoms persist or new symptoms occur.

This consent indicates your awareness of the treatment to be administered and the conditions being addressed. The undersigned hereby agrees that no guarantees of result are given or implied.

I have fully read and understand the foregoing.

Signature: _____

Date: _____

Send all completed forms to:

Betty deMaye-Caruth, PhD, RN, CHTP, RM/T
52 Deer Lane
Honesdale, PA 18431
570-253-8060

Website: www.minervaed.com

Email: minervaed@aol.com



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INTAKE INTERVIEW

DATE: _____

NAME: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY/STATE/ZIP: _____ HOME PHONE: _____

EMAIL: _____ WORK PHONE: _____

OCCUPATION: _____

PRESENT AILMENTS: _____

ARE YOU UNDER A DOCTOR'S CARE? YES NO

IF YES WHO? _____ OF WHERE? _____

LIST ANY MEDICATIONS/SUPPLEMENTS/VITAMINS YOU ARE TAKING: _____

HAVE YOU EVER EXPERIENCED ENERGY WORK BEFORE? YES NO

IF YES, WHAT TYPE? SHIATSU REIKI THERAPEUTIC TOUCH

HEALING TOUCH OTHER _____

IF YES, BY WHOM? _____ OF WHERE? _____

HOW DID YOU LEARN ABOUT THIS PRACTICE? ADVERTISING FRIEND

NEWSLETTER WELLNESS DIRECTORY WEBSITE OR

REFERRED BY: _____



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LIFESTYLE EVALUATION

MARITAL STATUS: SINGLE MARRIED SIGNIFICANT OTHER DIVORCED

LIVING SITUATION: ALONE OTHER ADULTS CHILDREN PETS PLANTS

TYPE OF HOME: SINGLE FAMILY APARTMENT QUIET NEIGHBORHOOD

BUSY NEIGHBORHOOD

ENERGY LEVEL: GENERALLY GOOD TIRE EASILY SEASONALLY INFLUENCED

STRESS INFLUENCED

STRESSORS: WORK FAMILY CAREGIVER OTHER _____

STRESS REDUCTION: EXERCISE MEDITATION HOBBY PERSONAL TIME

SPIRITUAL PRACTICE OTHER _____

EXERCISE HABITS: REGULAR SPORADIC DO NOT EXERCISE AT THIS TIME

SLEEPING HABITS: SLEEP DEEPLY, RARELY WAKE RESTLESS, WAKE EASILY

REMEMBER DREAMS WAKE TO USE BATHROOM, FALL BACK ASLEEP EASILY

OTHER _____

EATING HABITS: _____

SIGNIFICANT MEDICAL HISTORY (surgery, etc): _____

PHYSICAL EXAM: DATE OF LAST EXAM: _____ PHYSICIAN: _____

SIGNIFICANT SCARS: _____

CHRONIC PROBLEMS: _____

ALLERGIES: _____

ADDITIONAL COMMENTS: _____
