EFT/PSYCH-K® Intake Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married/Single/Divorced/Separated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Children: \_\_\_\_

Other Significant Relationships:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What issues or goals would you like to work on?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with any medical or psychiatric condition? Yes/no

If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion/Spiritual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any pet allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If our session is 100% successful, what would change in your life as a result?

*(See next page for informed consent agreement)*

Informed Consent Agreement

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that Victoria Vines is not a licensed therapist or psychologist and offers her services (PSYCH-K**®**, EFT (Emotional Freedom Techniques), Bioenergetic Assessment, etc.) as a self-help educator and Holistic Health Practitioner only.

I am aware that Victoria Vines does not diagnose illness or disease, and does not prescribe medications.  I agree not to discontinue or change any medications I am taking while working with Victoria Vines without first consulting my doctor.  *(Please initial) \_\_\_\_*

I understand that Holistic Health recommendations, EFT, and PSYCH-K**®** are considered experimental procedures and are not a substitute for medical, psychological or psychiatric treatment or medications, and that it is recommended that I currently work with my primary caregiver for any condition I may have.  *(Please initial) \_\_\_\_*

I understand that EFT and PSYCH-K**®** procedures may bring unresolved and distressing memories and related emotions and physical sensations into my awareness, and it is possible that disturbing material may continue to surface after a session and require further work.   *(Please initial) \_\_\_\_*

I also understand that previously traumatic memories may lose their emotional charge and this could adversely affect my ability to provide convincing legal testimony.  *(Please initial) \_\_\_\_*

I understand that all information I share with Victoria Vines is confidential and that no information will be released to any third party without my express written consent, with the following exceptions:  
 - When there is imminent risk of danger to myself or another person  
 - When there is suspicion that a child or elder is being sexually or physically   
 abused or is at risk of such abuse  
 - When a valid court order is issued for session records  
*(Please initial) \_\_\_\_*

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Victoria Vines from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

I give Victoria Vines permission to describe the details of my sessions to colleagues and/or mentors for supervision purposes only, as long as my personal anonymity is strictly protected.   *(Please initial) \_\_\_\_*

I honor Victoria Vines’ time and agree to pay 25% for any booked sessions that have not been canceled 24 hours in advance.  *(Please initial) \_\_\_\_*

(continued on next page)

I agree to take complete responsibility for my own comfort, health and well-being while working with Victoria Vines.  I agree that typing in my name below is the electronic equivalent of my actual signature.  *(Please initial) \_\_\_\_*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_  
Client Signature Date