Date_____ **[FIELDSCAPE LLC: CLIENT BACKGROUND INFORMATION FORM]**

Please complete this background information form to the best of your ability. This information will be used to help the practitioner work with you to achieve your goals. It is the goal of Fieldscape LLC to work in partnership with you to maintain the integrity of your bio-field and to assist you with your process of achieving wellness.

Last Name*	
First Name*	
Phone Home*	
Phone Cell*	
Email Address*	

Address*	
Line 1	
Line 2	
City	
State	
Zip Code	
Country	

Birthdate*	
Gender*: Male/Female	

Women: Are you pregnant?*	
Yes	No
Do you have a heart pacemaker or any form of electronic implant?*	
Yes	No
Are you (client) under 6 years old?*	
Yes	No
Have you had an organ transplant?*	
Yes	No

Health Concerns or Symptoms*

Diagnosed Health Conditions (by licensed physician)*

Current Medications (and what they are prescribed for)*

Past Surgeries*

Compromised Organs (from physical trauma, disease, substances, medical intervention, etc.)*

Known Allergies*
Supplements, Herbs or Natural Remedies currently being used*

Medical or Natural/Alternative Treatments currently being utilized*

How is your sleep, and how much do you typically get?*

How much exercise do you get, and what type?*

Briefly describe your dietary habits.*

Briefly describe your drinking habits, including how much water, coffee, juice, soda and alcohol you typically drink.*

Do you drink diet soda?*	
Yes, often	
Yes, rarely	
No, never.	

Do you smoke?*	
Yes	
No	

Do you have diabetes or any other known blood sugar condition?*	If yes, please describe.
Yes	
No	
If you have received energy remedies or healing in the past, do you consider yourself sensitive or highly responsive to it?*	
Yes	
No	

Please explain what you would like to achieve from your visit with Fieldscape LLC.*
How did you hear about Fieldscape LLC?*