CONFIDENTIAL CLIENT RECORD

ART OF SPIRITUAL CARE WITH NATALIE KAY

Full Name:	DOB:
Address:	
Phone:	Occupation:
Email:	

Referred by:	Physically related hobbies/ sports/ work:

Reason for Visit, brief description:

I am interested in receiving care: notes:

- ☐ Emotional Support & Spiritual Care:
- ☐ Self-Inquiry/ Psychotherapy:
- ☐ Bereavement Support:
- ☐ Injury or Illness Support:
- ☐ Palliative Support/ Life Review:
- ☐ Funeral or Celebration Ritual Preparation:
- ☐ Body Awareness:
- ☐ Stress Reduction:
- ☐ Therapeutic Touch:
- ☐ Harmony Me Healing
- ☐ Healing Art Practice:
- ☐ Professional Support/ Reflection:
- ☐ Other:

Please note if you have any symptoms/ condition	
Any Mental Health diagnosis, including treatment:	
Any recent diagnosis, disease progression, remission: including treatment:	
Any recent or significant life loss, bereavement, change?	
Current Medications:	
Health Professional Details – GP/ Psych etc.	

PERSONAL HISTORY

For safety and for treatment planning, it is helpful for your care provider to be aware of all life history related to seeking care, and/or all medical conditions for which you have been diagnosed or experienced.

Physical | *Musculoskeletal, Endocrine, Dental, Gastrointestinal, Urinary, Sleep, Circulation, Cardiac, Respiratory, Immune, Reproductive, Fertility. Any previous surgeries? Other? Please describe:*
Mental/ Emotional | *Migraines/Headaches, Poor Memory/Concentration/Recall, High Stress, Over-whelmed Easily, Fatigue, Depression, Mood swings, Excess Worry, Anxiety, Suicidal thoughts, Anorexia/Bulimia. Other? Please describe:*
Nervous System | *Dizziness, Tremors, Nervousness Tingling/Pins & Needles, Numbness, Shooting Pains, Restless Legs, Unsteady Gait, Low/Erratic Energy Levels, Pain on one side of body, poor balance. Other? Please describe:*
Spiritual/ Religious or none | *No faith identity, life expression/ creativity, religious faith community, informal faith identity, denominational membership, religious rituals or spiritual disciplines. Other? Please describe:*
Social | *Community groups, hobbies, volunteering, sport. Other? Please describe:*
Accident/Disaster | *Workplace, vehicle, sporting, climate related, war, community disaster. COVID, Other? Please describe:*
Personal or Familial Trauma | *Adverse Childhood Experiences or adolescence, or adult. PTSD/ cPTSD diagnosis. Sudden death or loss of loved one. Divorce. Witness of accident, assault. Other? Please describe:*
Psychological, Complementary, Therapeutic and/or Pastoral History | Have you engaged in counselling, therapy, pastoral/ spiritual care previously? Was it helpful, why/ why not? Are you seeking specific therapeutic care other than talk-based therapy?

CLIENT CONSENT WAIVER

I _____ verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential unless I provide written consent. I hereby give my consent to receive treatments and I acknowledge and agree that I am doing so at my own risk. My health and safety with respect to such services are my sole responsibility. My decision to receive services is voluntary, and I know of, understand and assume any and all the risks associated therewith.

In exchange for receiving services for myself and on behalf of my heirs, executors, administrators and personal representatives, hereby waive, release, discharge and hold my therapist harmless from any and all liability for any and all injuries, including damages or claims relating to or resulting from my receipt of the services, now or in the future, foreseen or unforeseen.

Please take a moment to read and initial the following information:

- If I experience pain or discomfort during the session, I will immediately inform my therapist.
- I will not hold my therapist responsible for any pain or discomfort I experience before, during or after the session.
- I understand that the services offered today are not a substitute for medical care.
- I understand that my therapist is not qualified to conduct a medical examination or provide a diagnosis and I agree not to interpret their comments as medical advice.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition.
- I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that treatment is non-sexual in nature.
- I understand my medical information and treatment notes may be released too other, third-party, health practitioners whom I agree for my therapist to refer me to.
- I agree that my therapist will need to disclose my personal information, if required to by law.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present and future relating to this treatment.

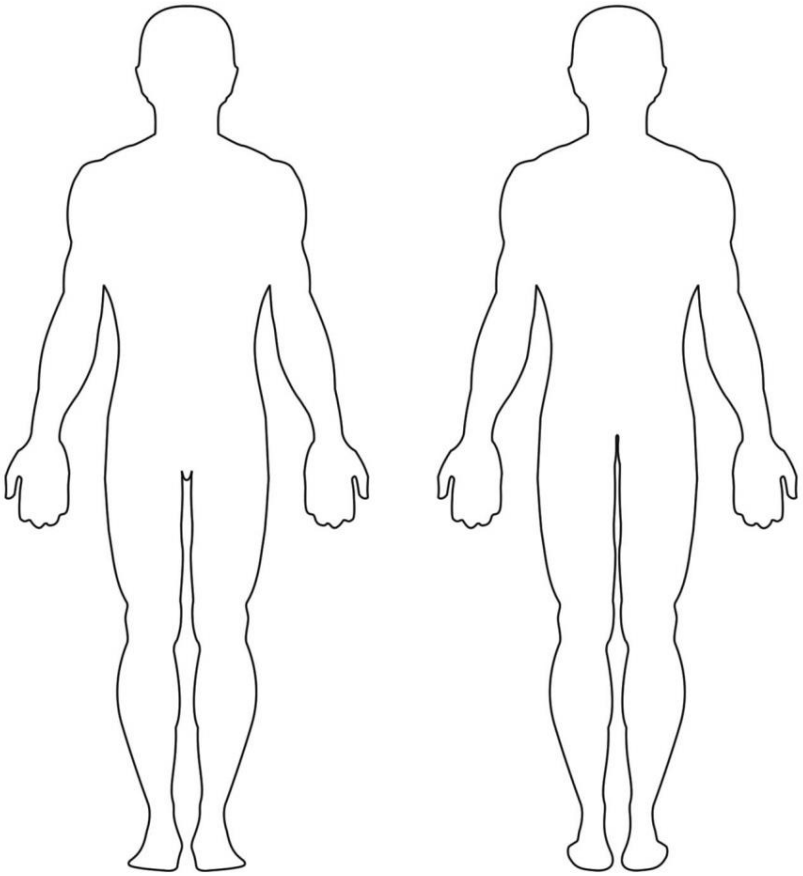
I have read the Art of Spiritual Care website, noting Natalie's Therapeutic Approach, Values and Principles of Care, Beliefs & Spirituality and am aware of her professional history, training and influences.
YES ☐ **NO** ☐ **INTIALS**
Late Cancellation Policy: I am aware that a fee applies when bookings are cancelled with less than 24hours notice. The fee will be the same as your booked session.
YES ☐ **NO** ☐ **INTIALS**

Client name		**Sign/ Date**	
Therapist name		**Sign/ Date**	

Feel free to ask any questions before, during, or after the session, Natalie will be happy to assist with any queries or concerns.

CLIENT BODYSCAN

Name:	Date:



What life experience, symptoms and/or pain are disrupting your ability to find ease and enjoyment in life? Have you discussed this with any other medical or allied help professional? Pain scale – low 1 2 3 4 5 6 7 8 9 10 high
Skin quality: do you have any rashes, open sores or wounds?
Injury: do you have historical or current injury sites?
Do you hold stress in your body? Where?
Are you aware of numbness in your body, or even a sense of emotional numbness? Describe this sensation…
As discussed per therapeutic plan, I consent to non- sexual touch for the needs of my body, aid self-awareness, and provide therapeutic support to aid my wellness journey. *INTIALS____*