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Metaphysical Services
 Spiritual Mind Treatment, Meditation Guide
 Somatic Therapy, Life Path Revision
 Neuro-Linguistic Programming
 Energy Infusion/Extraction, Ceremonialist
 Educator, Lecturer, Poetic Orator & Writer

For a complimentary 15 minute phone consultation, please call or text 909-351-0585 to schedule!

International Metaphysical Ministry Member

Trained Facilitator of The Sedona Method
 If you would like assistance with emotional or physical sensations you are wanting to release and let go, or even hold onto, then Call or Text Me for a complimentary consultation today!



New Client Intake Questionnaire: Please fill in the information below and email it back (clear photo is acceptable) to MyWordAsMyWand@gmail.com Please note: Your information provided on this form is protected as confidential information; however, email/text correspondence is not considered to be a legally secure medium of communication.

Date and Time of Initial Consultation: ___/___/___ @ ___:___ a.m./p.m. via telephone call from 909-351-0585

Today's Date: _____

Your First & Last Name: _____ Preferred Name: _____

Cell / Home Phone Number you would like to use for the telephone consultation: (_____) _____

May we leave a message? Yes No May we Text you? Yes No May we Email you? Yes No

Email address: _____ Cell/Work/Other Phone (optional): (_____) _____

Emergency Contact Info: _____ (_____) _____

Name of Emergency Contact	Relationship to Contact	Phone # of Emergency Contact
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Your Home Address: _____

DOB: _____ Age: _____ Are you aware that insurance payment is not accepted at this time? Yes No

Are you aware that secure payments are serviced only through Zelle at this time? Yes No

When you become a client, are you able to cover the session rate of \$100.00/hour? Yes No

Your Pronouns: He/him/his She/her/hers Them/they/theirs **LGBTQ+:** Yes No Prefer not to state

Marital Status: Never Married Domestic Partnership Married Separated Divorced Widowed

Background/Ethnicity (Optional): _____

Referred By (if any): _____

Brief History: Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? No

Yes, previous dates/range/years of treatment: _____

Are you currently taking any prescription medication? Yes No If yes, please list:

Have you ever been prescribed psychiatric medication? Yes No If yes, please list and provide dates:

Have you ever been hospitalized for a psychiatric condition? Yes No

If yes, please list and provide dates & specify diagnosis _____
