

RECONNECTIVE HEALING ® AND THE RECONNECTION ®

CONFIDENTIAL QUESTIONNAIRE -

All information will be kept strictly confidential except that which I am legally obliged to report, such as a threat of injury to yourself or others. Please return the form electronically or by post in time for the appointment and bring a signed copy with you.

NAME

DATE OF BIRTH

AGE

ADDRESS

TOWN

COUNTRY

POSTCODE

PHONE

MOBILE

EMAIL

How did you hear about me

Signature: _____

Please note:- (If under 18 Parent/Guardian signature required)

Date: _____

PLEASE NOTE: I can often re-arrange appointments if necessary but if you need to re-arrange or cancel with less than 48 hours notice, I may need to charge you for your missed appointment.

*I acknowledge that I am not representing myself as a licensed healthcare practitioner.

You acknowledge that you are accepting services under free will and without guarantee.

That this is about balance-healing on any level.

You acknowledge that you will not discontinue your medication/s from your health care professional.

I am not treating anyone. You make your own decisions. With having no expectations; I don't know the form of healing it will take.