MERIDIAN 180

Uniting Eastern Energetic Arts and Western Science

# *Client "Getting to Know You" Form*

Thank you for choosing Meridian*180* as part of your health and wellness team! We look forward to helping you achieve your wellness goals through gentle Energy Kinesiology and stress release techniques. As you answer the following questions, please know that the more detailed you are in your answers, the better we can help you achieve your wellness goals.

Date: _____

***Client Contact Information***

*(If you are an adult and this appointment is for your minor child, please print the minor child's information here and your information under "Parent / Guardian Contact Information" below.)*

Client Name: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail:_____

Emergency Contact : (___)_____ Name / Relationship: _____

Are you OK with us taking your photo so it is easier for us to remember who you are? □ Yes □ No

***Parent / Guardian Contact Information (leave blank if over 18)***

Parent / Guardian Name: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail:_____

**Referred by:** _____

## *Client Information*

Date of Birth: _____ Age: _____ Birth Gender: □ Male □ Female Current Gender: □ Male □ Female

Sexual preference: □ Men □ Women □ Both □ Other: _____

Marital Status: □ Single □ Married/Domestic Partner □ Widowed □ Divorced

Work Status: □ Employee □ Self-Employed □ Unemployed □ Retired □ Disabled

Current Occupation: _____ Former Occupations: _____

Children (ages): _____

Hobbies / interests: _____

Pets: _____

Spiritual beliefs/religious affiliations, past, and present: _____

## *Health and Lifestyle*

Do you exercise? □ Yes □ No How often? _____

What activities? □ Walking □ Running/Jogging □ Weights □ Cycling □ Yoga □ Other: _____

Do you drink water? □ Yes □ No How much / often / source: _____

Have you ever smoked? □ Yes □ No How much / often: _____

Do you drink alcohol? □ Yes □ No How much / often: _____

Do you drink coffee? □ Yes □ No How much / often: _____

Do you take recreational drugs? □ Yes □ No How much / often: _____

Do you take supplements (vitamins, mineral, herbs)? □ Yes □ No How much / often: _____

_____

_____

_____

Source of social support: □ Family □ Friends □ Other □ No Support

Your "Wellness Support Team" (Chiropractor, Counselor, Naturopath, Life Coach, etc) _____

_____

_____

_____

How much uninterrupted sleep do you get each night, on average (hrs): _____

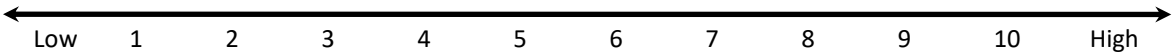
If you have trouble sleeping, what is the primary reason? □ anxiety □ discomfort □ outside interruption (family, noise)
□ Other: _____ □ I don't have trouble sleeping

What's your opinion of your overall diet: □ Very Healthy □ Somewhat Healthy □ Not Very Healthy □ Please Help Me

What's your opinion of your overall wellbeing: □ Excellent □ Good □ Fair □ I'd Like A Do-Over

## *Stress*

Circle your overall stress level:




Are you able to relax? □ Yes □ No

What do you do to relax? _____

Sources of comfort and connection? _____

What things create the greatest challenges for you? _____

What major life decisions or changes are you facing? _____

What are the major stressors in your life right now? _____

_____

What things or activities bring meaning, purpose, or joy to your life? What inspires you? _____

_____

## *Medical Information (optional for those who don't mind sharing)*

Known Medical Conditions: _____

_____

_____

_____

_____

Please list any medications you are currently taking: _____

_____

_____

_____

_____

Do you wish to stop taking medications if possible? □ Yes □ No

Past Surgical History: _____

_____

_____

Please mark the items below with 1-10. "1" indicates a very minor issue, concern, or problem. "10" indicates a major issue, concern, or problem. "Past" means anything more than 6 months ago. "Recent" means anything within the last 6 months. **If it does not apply to you, leave it blank.**

| Past | Recent | |
|---|---|---|
| | | Abandonment |
| | | Academic challenges |
| | | Acne |
| | | Addictions |
| | | Agitation / irritability |
| | | Alcohol use |
| | | Allergies / sensitivities |
| | | Anemia |
| | | Anxiety / worry |
| | | Apathy |
| | | Asthma |
| | | Atypical menstrual bleeding |
| | | Auditory issues / hearing |
| | | Birth complications |
| | | Bladder infection |
| | | Block love from others |
| | | Blocked creativity |
| | | Blood clots |
| | | Blood pressure |
| | | Blood work / lab test results |
| | | Body range of motion / flexibility issues |
| | | Breaking family patterns |
| | | Breathing issues |
| | | Broken/fractured bones |
| | | Caffeine use |
| | | Cancer |
| | | Can't express emotions |
| | | Can't express love |
| | | Career issues |
| | | Change in appetite |
| | | Changing repetitive actions |
| | | Cholesterol |
| | | Clarity of thought |
| | | Clenching jaw |
| | | Cold feet or hands |
| | | Cold or heat intolerance |
| | | Communication issues |
| | | Compulsive behaviors |
| | | Conflicting emotions |
| | | Confusion |
| | | Constipation |

| Past | Recent | |
|---|---|---|
| | | Control / authority issues |
| | | Craves attention |
| | | Deep frustration or anger |
| | | Denial or avoidance |
| | | Depression |
| | | Diabetes / blood sugar issues |
| | | Diarrhea |
| | | Difficulty concentrating |
| | | Difficulty in home environment |
| | | Difficulty saying "No" |
| | | Difficulty urinating |
| | | Difficulty with change |
| | | Disabilities |
| | | Disconnected from body |
| | | Dizziness / balance / vertigo |
| | | Dread |
| | | Drug use |
| | | Eating issues |
| | | Environmental sensitivities |
| | | Excessive emotions |
| | | Excessive talking |
| | | Extreme introvert / extrovert |
| | | Fainting spells |
| | | Family relations / conflict |
| | | Fatigue / weakness / low energy |
| | | Fear or phobia |
| | | Feeling accepted |
| | | Feeling betrayed |
| | | Feeling grounded |
| | | Feeling like a victim |
| | | Fertility concerns |
| | | Food sensitivities |
| | | Forcing views on others |
| | | Forgetfulness |
| | | Gall bladder issues |
| | | Grief |
| | | Guilt or shame |
| | | Had an affair |
| | | Head injuries |

| Past | Recent | |
|---|---|---|
| | | Headaches / migraines |
| | | Heart condition |
| | | Heartburn / indigestion |
| | | Heavy metal / toxicity |
| | | High stress |
| | | Hoarding |
| | | Hormone issues |
| | | Hot flashes |
| | | Impulsive |
| | | Inability to connect with divine |
| | | Inability to have fun |
| | | Incontinence |
| | | Indecisive or indifferent |
| | | Infectious diseases |
| | | Inflexible with people |
| | | Insecurity |
| | | Insomnia / sleep issues |
| | | Interrupting |
| | | Intestinal gas / bloating |
| | | Irrational |
| | | Jealousy |
| | | Lack of purpose in life |
| | | Lack of sexual desire |
| | | Learning disability |
| | | Limiting belief systems |
| | | Listening |
| | | Live or work near industrial factory, power lines/stations, turbines, highway, airport, farm |
| | | Liver issues |
| | | Loss of appetite |
| | | Lying |
| | | Major life changes |
| | | Manipulative |
| | | Memory issues |
| | | Menopause |
| | | Money management issues |
| | | Mood swings / unstable emotions |
| | | Motion sickness |
| | | Nausea / vomiting |

Please mark the items below with 1-10. "1" indicates a very minor issue, concern, or problem. "10" indicates a major issue, concern, or problem. "Past" means anything more than 6 months ago. "Recent" means anything within the last 6 months. **If it does not apply to you, leave it blank.**

| Past | Recent | |
|---|---|---|
| | | Negative thoughts |
| | | Nervous stomach |
| | | Nervousness |
| | | Nicotine use |
| | | Nightmares |
| | | Numbness / tingling |
| | | Obsessive tendencies |
| | | Orphaned, adopted, fostered child |
| | | Overly competitive |
| | | Overly critical |
| | | Oversensitive emotions |
| | | Overwhelm |
| | | Pain / discomfort |
| | | Panic attacks |
| | | Paralysis |
| | | Performance stress (non-sexual) |
| | | Perfectionism |
| | | Pessimistic |
| | | Pesticide / insecticide exposure |
| | | Piercings / tattoos |
| | | Pleaser |
| | | PMS |
| | | Poor body image |
| | | Poor digestion |
| | | Poor organization |
| | | Poor personal boundaries |
| | | Poor posture / slouching |
| | | Poor social skills |
| | | Post-surgery issues |
| | | Powerlessness |
| | | Pregnancy issues |
| | | Pregnant currently |
| | | Pre-surgery preparation |
| | | Prideful |
| | | Primitive / postural reflexes |
| | | Problems walking |
| | | Procrastination |
| | | Reaction to vaccinations |
| | | Relationships |

| Past | Recent | |
|---|---|---|
| | | Ringing in the ear |
| | | Sabotaging |
| | | Scars |
| | | Self-condemnation |
| | | Self-esteem |
| | | Sensitivity to other's emotions, feelings, energy |
| | | Sensitivity to smell |
| | | Sensitivity to sound |
| | | Sensitivity to taste |
| | | Sensitivity to touch |
| | | Sensitivity to visual stimulation |
| | | Severe tension |
| | | Sexual issues |
| | | Sexual performance |
| | | Shortness of breath |
| | | Shyness / confidence |
| | | Sinus issues |
| | | Spasms / cramps |
| | | Speech issues |
| | | Spinal cord injury |
| | | Spiritual addiction |
| | | Spouse had an affair |
| | | Stroke |
| | | Struggle for survival |
| | | Struggling to develop personal talents / abilities |
| | | Stuck |
| | | Suicidal thoughts |
| | | Swelling |
| | | Teeth grinding |
| | | Thyroid issues |
| | | Time utilization |
| | | Too trusting or can't trust |
| | | Toxic relationships |
| | | Trouble swallowing |
| | | Twitching of face |
| | | Ulcer |
| | | Unable to feel emotions |
| | | Undesirable habits |

| Past | Recent | |
|---|---|---|
| | | Unhappy / down / depression |
| | | Unusual fears |
| | | Unwilling to communicate |
| | | Visual issues |
| | | Weak immune system |
| | | Weight gain |
| | | Weight loss |
| | | Other body issues |
| | | Other circulatory issues |
| | | Other digestive issues |
| | | Other ear issues |
| | | Other emotional issues |
| | | Other immune system issues |
| | | Other kidney / urinary issues |
| | | Other mental issues |
| | | Other nervous system issues |
| | | Other nose issues |
| | | Other reproductive issues |
| | | Other respiratory issues |
| | | Other skin issues |
| | | Other throat issues |
| | | Other visual issues |
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## *Personal History*

What traumas have you experienced? □ Child Maltreatment □ Community Violence □ Domestic Violence □ Medical

□ Natural Disasters □ School Related □ Sexual □ Traumatic Loss □ War Related □ None

What other events do you view as traumatic, or hold significant unresolved stress for you (your baggage): _____

_____

_____

If not identified elsewhere, list anything you think can never improve/change about that you wish would: _____

_____

_____

Is there anything else you think I should know? _____

_____

## *Wellness Goals*

What are the top changes you want to see in the following areas of your life?

Physical: _____

_____

_____

Mental: _____

_____

_____

Emotional: _____

_____

_____

Spiritual: _____

_____

_____

Relationships: _____

_____

_____

Professional: _____

_____

_____

# Meridian180 Client Consent Form

1430 Oak Court Suite 211 Beavercreek OH 45430 937-903-5576; doug@meridian180.com

**Scope of Practice and Service Approach**
Meridian180 uses an energy-based approach to facilitate stress release by identifying where a person carries stress, and assisting in releasing that stress through gentle touch. Our services may incorporate muscle monitoring which involves applying light pressure on a muscle. We do not diagnose or treat disease and are not physicians. Our services are not a substitute for diagnosis or treatment from qualified health practitioners for illnesses, injuries, or other medical conditions. Our services are not licensed by the state of Ohio.

**Description of a Session**
Clients typically lay face-up, fully clothed, shoes off, on a massage table. After identifying the session goal with the client, we facilitate the client releasing applicable stresses using light physical touch or hand motions near the body, including a dialogue about what the client is experiencing. Some clients feel nothing. Others describe sensations of energy movement, relaxation, or feelings of being supported and nurtured.

**Benefits of Energy Kinesiology**
Clients often report experiencing relaxation, an increased sense of well-being, peace that helps them better cope with illnesses, medical procedures, or medical conditions, or that their physical, emotional, mental and spiritual wellbeing has improved. Any changes that take place are solely due to the client activating their own innate self-healing capability. Because of this, we make no specific claims of the results from a session.

**Risks of Energy Kinesiology**
Energy Kinesiology is a non-invasive, non-medical energetic technique, still being researched by science, and currently has no known detrimental side effects. Occasionally, clients report feelings of vivid dreams, fatigue, dehydration, excessive energy, detoxification-like symptoms, discomfort, or unexplainable emotional releases.

**Energy/Educational, Training and Experience**
The state of Ohio has not adopted any educational or training standards for unlicensed complementary and alternative health care practitioners. This statement of credentials is for information use only: I am a certified level 3 Energy Kinesiologist with the Energy Kinesiology Association with over 2500 hours of specialized training in Neuroenergetic Kinesiology, Stress Indictor Point System (SIPS), EmpowerLife Kinesiology, Applied Physiology, Kinergetics, LEAP, and Touch for Health. I am a national instructor for multiple of these modalities. I have a Bachelor's Degree in Biology from Michigan Technological University, and a Master's Degree in Genetics and Molecular Biology from Emory University.

**Costs and Business Policies**
New session are 1.5 hours. Subsequent sessions are 1.25 hours. All cost $155. Sessions that run long are billed at $125/ hour in 15 min increments. If your body indicates the need to stop during the session, we will only charge you for the time used, or credit the remaining time to future appointments.

Payment in cash, personal check, or Business Zelle is expected at the time of service unless arranged in advance. We may accept partial payment, or at our discretion, waive payment, based on individual client circumstances. The above fees are subject to change at any time with 30 day notice. A $30 fee applies for returned check or insufficient funds. Clients must cancel appointments before 9am the day before their session, or be responsible for a $50.00 appointment cancellation fee. There are no large family or frequent session discounts. We retain the right to discontinue service to anyone at any time.

Doug Akerman is the sole provider of services, and therefore has no supervisor. Any complaints about services received should be filed directly with me using the contact information above.

**Confidentiality / Client Rights:**
All information shared and your experience during our sessions are confidential unless release of these records is authorized in writing by the client, subject to the following exceptions:

1. Meridian180 occasionally writes up session summaries for use in emails / social media to help people more fully understand what Energy Kinesiology is and how it can benefit them. Names, possibly sex, and any additional information that may indicate who someone is are changed, or excluded (sanitized).
2. Sanitized information may be used anonymously for teaching and training purposes if necessary.
3. Information may be released if legally obligated or reasonably allowed to do so (including circumstances where there is clear and imminent danger to yourself or another person).
4. Subject to the usual exclusions dictated by state and federal laws and regulations.

**ACKNOWLEDGEMENT, CONSENT, CLIENT PRIVACY RIGHTS**
I have read and understand the above disclosure regarding the services offered by Meridian180/Doug Akerman. We have discussed the nature of the services to be provided including that Energy Kinesiology is an energy based therapy accomplished through the use of light contact. I understand that he is not a licensed physician and his services are not licensed by the state of Ohio. I understand it is my responsibility to maintain a relationship for myself with a medical doctor, if I so desire. I further understand that the above named is not trained to diagnose illness, prescribe or make recommendations involving pharmaceutical drugs or surgery, handle medical emergencies, nor does he make any specific claims regarding results from his services that I receive.

I have read and understand the above disclosure regarding privacy policies and confidentiality, and that experiences during these sessions are confidential, but subject to the usual exceptions governed by laws of the State of Ohio and other federal laws and regulations.

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Meridian180/Doug Akerman from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

My questions have been answered to my satisfaction regarding Doug Akerman's background, typical session structure, and what I might expect from this session.

**I acknowledge that I have received, read and understand the Meridian180 Client Consent Form, and that I fully consent, now and for all future sessions, to it for services offered by Doug Akerman:**

Signed: _____ Date: _____

Print Name: _____

Address: _____

Would you like to be notified of upcoming classes and/or seminars? ☐ Yes ☐ No

May Meridian180 send you educational/promotional materials such as newsletters via e-mail? ☐ Yes ☐ No

Take The Meridian180 "More Than Me" Challenge: Once you have shown improvement and are finding relief from these things that are affecting the quality of your life, will you commit to 'Pay It Forward', and share with other people how Energy Kinesiology has helped your life? Possible ways to do this include telling friends and family about your experiences and encouraging them to get help with their issues, submitting Google and FB reviews, etc. ☐ Yes ☐ No