Eliyahu Sapir
body & emotional healing

Pre-treatment medical screening form

:First name	Family Name:	Date of birth:
Address:		Occupation:
Email address:		Phone number:

:Do you suffer from one of these conditions

1. A new pain that has not been medically examined?	Yes/no
2. Rapid heart beat (palpitations) that are not due to physical exertion?	Yes/no
3. Hematomas of the skin - blood spots under the skin as a result of bruises or pressure to the skin?	Yes/no
4. An orthopedic problem such as back or neck pain?	Yes/no
5. Osteoporosis?	Yes/no
6. Imbalanced blood pressure?	Yes/no
7. Cancer in the past five years?	Yes/no
8. Shortness of breath?	Yes/no
9. Diabetes?	Yes/no
10. Heart problems?	Yes/no
11. Dizziness or fainting?	Yes/no
12. Depression?	Yes/no

If you have answered in the affirmative to one of these questions please give further details:

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The energy treatment cannot be given if you suffer from any of the following conditions:

1. Are you pregnant?	Yes/no
2. Are you not able to climb a flight of stairs **without** experiencing chest pains and shortness of breath?	Yes/no
3. Have you had a stroke, a neurological disorder, or paralysis of part of your body?	Yes/no
4. Are you suffering from a mental illness (other than depression)?	Yes/no

Declaration:

I confirm that I am aware that the treatment I am requesting is not a substitute for any conventional medical treatment or consultation with a medical doctor.
I declare that I will not stop taking prescribed medication without consulting a doctor.
I confirm that my answers to the questions in this questionnaire are truthful and complete and that I have not withheld any information.

Date_____ **signature**_____