



Co-Creative Mentoring

Sheryl Harrell, MA/A.B.S., BCC

1101 E. Elizabeth St.
Fort Collins, Colorado 80524
970.221.3898

Date: ___/___/___ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Birthdate: ___/___/___ May I add you to my email list? Y N

How did you hear about Co-Creative Mentoring? _____

Have you experienced EFT or other energy modalities before? Y N Which modalities? _____

Living situation: married / partner / single # of children: _____ Occupation: _____

Health care professionals you are currently working with (circle all that apply): MD DO Chiropractor Acupuncturist
Massage Homeopathist Other: _____

Are you currently taking any medications? Y N List: _____

Have you had any illnesses, injuries, trauma, or surgeries that may be affecting your health now? Y N Explain:

Are you currently experiencing any symptoms (pain, tension, anxiety, etc.)? Y N Explain:

How does this affect your daily activities (sleep, exercise, decision-making, relationships)? _____

For those symptoms/concerns that apply to you, please rate your distress level for each using the scale below:

0	1-2	3-4	5-6	7-8	9-10
None	Very little	Somewhat	Moderate	Considerable	Maximum

___ Depression ___ Mood swings ___ Anger ___ Alcohol/drug use ___ Sleep problems ___ Anxiety ___ Panic attacks
 ___ Memory problems ___ Eating problems ___ Hormonal imbalances ___ Allergies _____
 ___ Stress (work) ___ Stress (home) ___ Other _____

How stress manifests: _____

Religious/spiritual practice: _____

What is your goal for today's session? _____

Long term wellbeing goal/s: _____

In case of emergency, I authorize Sheryl Harrell to contact the following person/s:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Anything else you would like to tell Sheryl? Questions? _____

Thank You