

Spirit Attachment Assessment Form
*Client Intake & Evaluation for Attachment Removal*
Confidential – For Use by Amy Major Only

Submit this completed form along with a recent photo to: amymajormedium@gmail.com
Subject Line: Attachment Removal

Confidentiality Statement

All information provided in this form is kept strictly confidential and used solely for the purpose of assessing spiritual or energetic attachments. Your information will not be shared with any third parties, unless required by law in situations where there is a threat to your safety or the safety of others.

Client Information

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Location (City, State, Country): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Preferred Contact Method (Phone / Zoom): \_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact Name & Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Disclosure

* Are you currently receiving treatment for any mental health condition?
☐ Yes ☐ No
* If yes, please specify the diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are you under the care of a licensed therapist, psychiatrist, or counselor?
☐ Yes ☐ No
* Therapist Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you informed your mental health provider of this spiritual service?
☐ Yes ☐ No
Note: Your mental health provider must be informed of your participation in spiritual services. This is for your safety and optimal healing integration.

Attachment Situation Overview

1. Describe the current situation or concerns that prompted you to seek attachment removal:
2. What have you tried in order to resolve the issue? (spiritual, medical, or psychological support):
3. What are you hoping to achieve through this session?

Symptom Assessment

Please describe any symptoms you are experiencing:

Physical Symptoms:

Mental/Emotional Symptoms:

Psychological or Behavioral Symptoms:

Manifested (Self-Created) Attachment Questionnaire

Answer each question True or False (T/F):

| Question | T/F |
| --- | --- |
| Have you ever experienced trauma in your life? If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Have you experienced any form of abuse (physical, emotional, sexual, psychological)? |  |
| Are there times in your life you cannot remember? |  |
| Do you feel in full control of your emotions? |  |
| Do you feel in full control of your thoughts? |  |
| Do you feel in full control of your actions? |  |
| Do you suffer from any chronic illnesses that persist without diagnosis? |  |
| Do you experience recurring dreams, nightmares, or sleep disturbances? |  |
| Do you believe your life is cursed or unable to change for the better? |  |
| Do you often feel like a victim in life? |  |
| Do you have coping mechanisms that others may consider strange? |  |
| Do you struggle with substance abuse (alcohol, drugs, etc.)? |  |
| Do you experience sexual or reproductive health issues? |  |
| Do you dislike or hate your body? |  |
| Do you find pleasure in pain or discomfort? |  |
| Are you frequently sad or depressed? |  |
| Do you suffer from PTSD, ADD, ADHD, or OCD? |  |
| Do you disconnect from reality for comfort or escape? |  |
| Do you feel emotionally distant from loved ones? |  |
| Do you ever feel like hurting yourself? |  |
| Are you currently suicidal or have had suicidal thoughts? |  |

*If you answered TRUE to 3 or more of the above, this may indicate a manifested attachment.*

👁️ Intelligent (Spirit or Entity) Attachment Questionnaire

Answer each question True or False (T/F):

| Question | T/F |
| --- | --- |
| Do you feel like you're being watched? |  |
| Do you see disturbing images in your mind? |  |
| Do you hear voices internally or externally? |  |
| Do you hear whispering or unclear sounds? |  |
| Do you experience disturbing dreams or nightmares? |  |
| Do you have headaches or vision disturbances? |  |
| Do you suffer from unexplained fatigue or exhaustion? |  |
| Do you feel heaviness, pain, or soreness in your body without cause? |  |
| Do you experience stomach pain or digestive issues? |  |
| Do you bruise easily or wake with scratches/bruises you can’t explain? |  |
| Do you suffer from chronic illness or pain without diagnosis? |  |
| Have you experienced recent unexplained changes in your physical body? |  |
| Do you feel something moving inside your body? |  |
| Do you feel pressure or expansion in your energy field or body? |  |
| Have you experienced body twitching/movements out of your control? |  |
| Has your personality or behavior changed unexpectedly? |  |
| Have you developed sudden habits (e.g., substance use, addictions)? |  |
| Have you distanced yourself from loved ones without cause? |  |
| Do you feel like you're losing your mind or sense of reality? |  |
| Do you feel like harming yourself? |  |
| Are you currently suicidal or have suicidal thoughts? |  |

*If you answered TRUE to 3 or more of the above, this may indicate an intelligent attachment.*

Signature & Acknowledgment

I confirm that the information provided above is truthful to the best of my knowledge. I understand that Amy Major is not a licensed medical or mental health provider, and that spiritual services are not a substitute for medical or psychological treatment. I understand that Amy may refer me to a medical or mental health professional if needed.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_