Crystal Healing Session Record

Please clearly print while filling out this form. Complete the following to the best of your ability. This information will remain strictly confidential and is provided to assist the therapist in performing healing techniques. If you do not feel comfortable responding to any of the following areas, then please leave them blank. If you do not know how to respond to any of the following, please mark them with a "?"

Client's Name: _____ **Date:** _____
Last Name, First Name Middle Initial

Address:

_____
Street Apt #

_____
City State Zip Code

Telephone (with area code):

_____
Home Work Cell

Date of Birth: _____ **E-mail:** _____

Gender: _____ **Marital Status:** _____

Occupation: _____

Emergency Contact:

_____
Name Phone Number Relation to Client

Please mark any conditions that apply to you:

__headache, migraines
__vision problems, contact lenses
__hearing problems, deafness
__injuries to face or head
__sinus problems
__dental bridges, braces
__jaw pain, TMJ problems
__asthma or lung conditions
__constipation, diarrhea
__hernia
__birth control/IUD
__abdominal or digestive problems
__chronic pain
__muscle, bone injuries
__numbness or tingling
__sprains, strains
__arthritis, tendonitis
__cancer, tumors
__spinal column disorders
__diabetes
__pregnancy
__heart, circulatory problems
__muscle or joint pain
__other conditions not listed*
__fatigue
__tension, stress
__depression
__sleep difficulties
__allergies
__rash, fungal issue
__infectious illness
__blood clots
__varicose veins
__blood pressure (high or low)
__back problems

Details:

_____

_____

To help serve you better, please answer the following by circling a response:

1. Do you smoke?.....Yes.....Rarely.....No
2. Do you take any prescribed medications*.....Yes.....Rarely.....No
3. Do you drink alcoholic beverages?.....Yes.....Rarely.....No
4. Do you have a history of contagious disease(s)*.....Yes.....No
5. Do you have a history of serious physical injury?*.....Yes.....No
6. Do you have a history of psychological disorder?*.....Yes.....No
7. Are you pregnant?.....Yes.....No
8. Do you have high blood pressure?.....Yes.....No
9. Have you had any surgeries or hospitalizations?*.....Yes……No
10. Have you had any professional counseling or therapy?.....Yes……No

***Details:**

_____
_____
_____
_____
_____

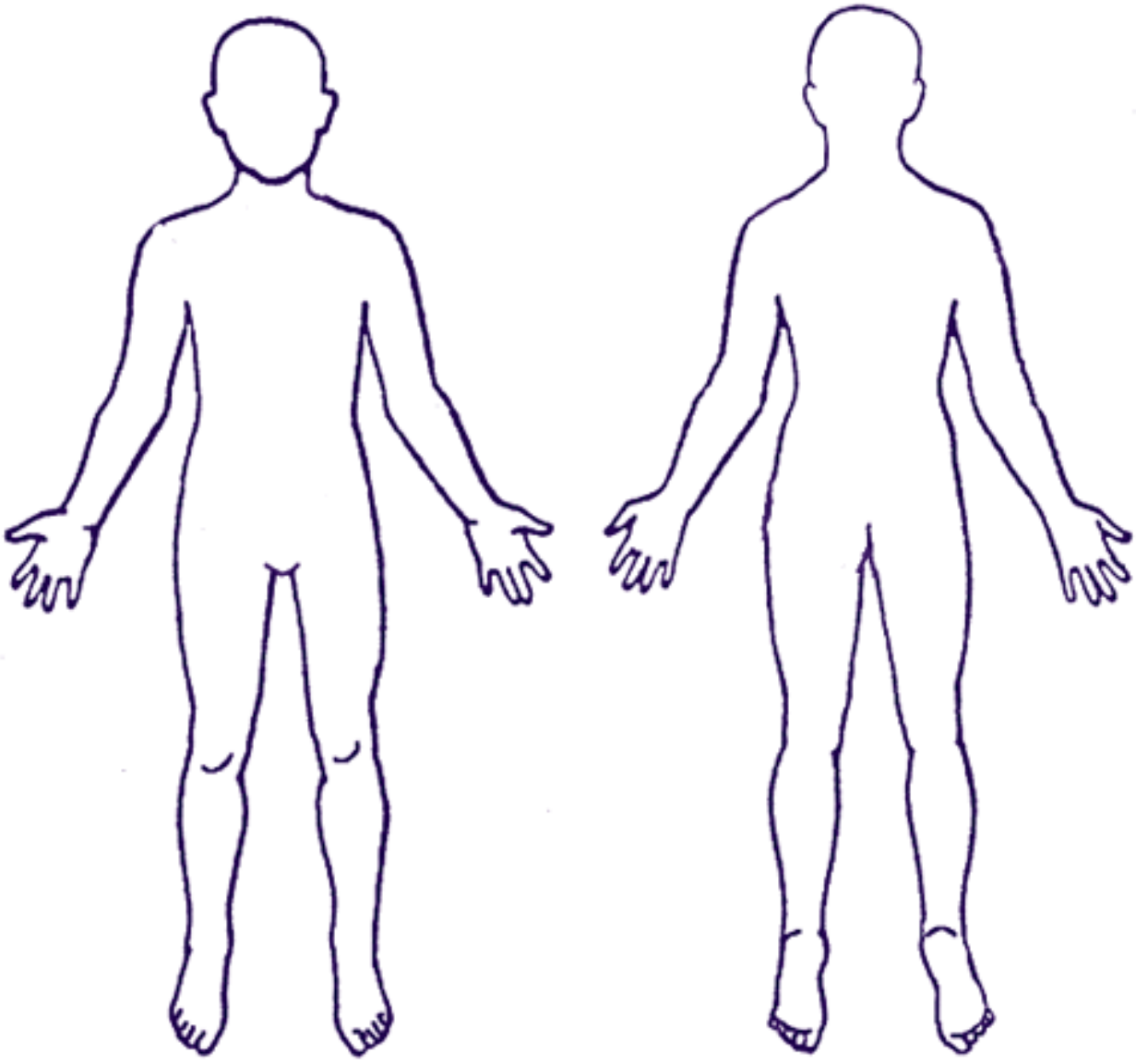
Do you follow a spiritual practice, if so what?

_____
_____
_____
_____
_____

Purpose of visit (symptoms, complaints, problems):

_____
_____
_____
_____
_____

Please mark any areas of your body where you feel discomfort:



FRONT **BACK**

In general, how are you feeling today (i.e. I'm tired from grocery shopping and my children were a handful this morning, or, I am skeptical about this session but I am willing to give it a try)**?**

_____
_____
_____
_____
_____

Please sign and date below to state that the information provided is true to the best of your knowledge. By signing below you are stating that you understand that Crystal Healing is not meant to replace conventional medicine, but rather to complement and enhance it. A medical professional should always be consulted. By signing below, you hereby release the person providing the crystal healing session from any liability as a result of the service performed.

Signature of Client: _____ Date: _____

Signature of Crystal Healer: _____ Date: _____

Would you like to be contacted about future promotions or offers from this healer? (Please circle one)..........Yes.....No

How did you hear about this crystal healer (Please mark any that apply)?

__ The internet (please specify) _____
__ Directory/Yellow Pages (please specify) _____
__ Referred by a friend (please specify) _____
__ Other (please specify) _____