MY CHAKRA CENTER
Client Intake Form

Name:	Date:
Address:	Phone:
City, State, Zip	Email:
Date of Birth:	Referred by:

GENERAL HEALTH

Methods of relaxation you practice in your daily life:
What is the main source of stress in your life?

Do you have any difficulty lying on your front or back?
Any accidents or surgeries in last 2 years?
Do you have any metal implants, a pacemaker or body piercings?

ENERGY HEALING

Have you ever experienced: Vibrational Sound Healing ____ Reiki ____ Chakra Balancing ____ Siwa Murti ____

Do you have any sensitivity to sound or vibration?
Is there any area of your body you do not want sound bowls to be placed?
Are there any specific areas of your body that you want to focus healing on?

HEALTH HISTORY

Heart Condition	Psychiatric Disorder	Allergies
Numbness/Tingling	Sinus Problems	Spasms/Cramps
Rashes	TMJ Dysfunction	Sprain/Strains
Diabetes	Gas/Bloating	High/Low Blood Pressure
Epilepsy	Pregnancy (__ weeks)	Fatigue/Sleep Disorders
Stroke	Herpes/Shingles	Headaches
Broken/Fractured Bones	Blood Clots	Arthritis
Chronic Pain	Paralysis	Depression/Anxiety
Constipation	Varicose Veins	Other:

GOAL

Relaxation	Pain Relief	Stress	Personal / Spiritual Development

It is my choice to receive an energy healing session and I understand that the practitioner will be working with loving and compassionate intention and may be using gentle sound and vibration during these sessions on/around me. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update my practitioner of any changes to my health status. I understand that practitioners from My Chakra Center do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments or pharmaceuticals. I acknowledge that these sessions are not a substitute for medical examination or diagnosis and recommended that I see a primary health care provider for those services. I understand that I alone am responsible for informing my primary health care provider that I am receiving these sessions and inquiring as to whether or not they may adversely affect my current health condition.

_____

Client signature Date

Privacy Policy: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.