

Cosmic Healing for the Body, Mind, Spirit
Client Information Form

Name: _____ Month & Year of Birth _____

Address: _____ city _____ state _____ zip _____

Phone #: _____ email: _____

I would like to be contacted for appointment reminders. Yes ___ No ___

I would like to receive occasional emails, updates, newsletters by Cosmic Healing. Yes ___ No ___

Is this the first time you have received a massage Yes ___ No ___ Energy work: Yes ___ No ___

Sound Healing Yes ___ No ___

Do you have:

Skin problems or allergies: Yes ___ No ___

Varicose Veins and/or blood clots: Yes ___ No ___

Arthritis or joint disorders: Yes ___ No ___

Spinal Problems: Yes ___ No ___

Are you currently experiencing pain: Yes ___ No ___ where: _____

Have you taken or had alcoholic beverages in the last 48 hours: Yes ___ No ___

Do you have any medical conditions, medications, treatments or emotional challenges I should be

aware of before the session? Please share _____

What are your intents and expectations for this session? _____

Client Consent:

Sessions for sound, energy and massage are for the purpose of relaxation, and enhancing wellbeing of the body, mind and spirit. I will immediately inform the therapist of any discomfort during the session. I understand that sound, energy and massage sessions should not be construed as a substitute for medical examination, diagnosis, or treatments. The therapist is not qualified to make a diagnosis, write prescriptions, adjustments or treat mental illness and nothing in the course of the session(s) should be construed as such. Sound, Energy and Bodywork may not always be warranted under certain medical conditions. I affirm that I have stated all my known medical conditions and answered honestly. I agree to update my therapist on any changes to my medical condition and that there will be no liability on the therapist's part if there is not full medical disclosure. I understand any and all illicit and sexually suggestive remarks or advances made by me to the therapist will result in immediate termination of the session. I understand payment is due at time of service.

Privacy Policy: All information shared in sessions is private and confidential. Only if required by the law and authorized by you will information be shared with others.

Client Signature: _____

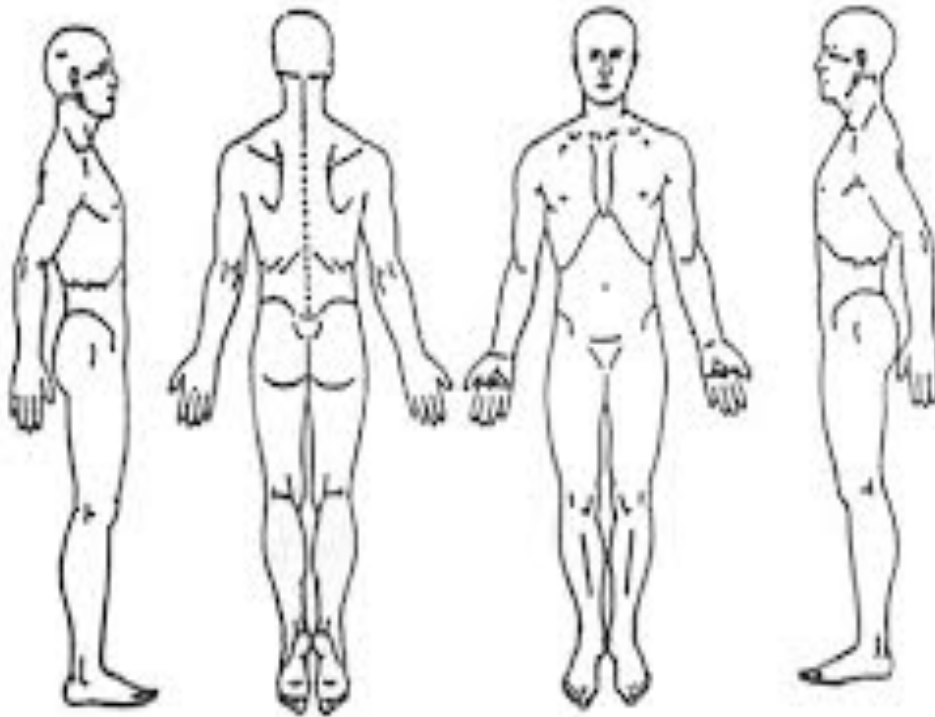
Date: _____

Client Intake Form:

How many hours of sleep per night do you get on average: _____ last night _____

Directing Bodywork to specific areas may alleviate or lower pain. Please indicate the areas on the body forms below where you experience pain with the numeric level between 1-10. 1 being low to 10 being intolerable.

Please indicate, if able, how long you have had the pain and what else was occurring in your life at the onset of symptoms.



Session Notes: _____
