

# CLIENT INTAKE FORM

Name:		Date:	
Address:		BirthDay:	
		E-Mail:	
Phone(s):		Single <input type="checkbox"/> Partnered <input type="checkbox"/>	
Occupation:		Children:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nationality:		Referred By:	
Please describe any chronic / hereditary / congenital problems.			
Where in your physical body are weak or vulnerable areas?			
Have you had any surgeries or hospitalizations? If so, when and what for?			
Are you presently taking any medication? If so, what and what for?			
Have you had any experience with crystals or stones? If so, what?			
Have you had any counseling before?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you meditate?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a spiritual practice? If so, what?			
What emotion do you feel you least express?			
What emotion do you feel you most express?			
What else you would you like me to know?			
Please summarize what you want to accomplish during your crystal session.			