

## CRYSTAL HEALING INTAKE & CONSENT FORM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

PROVIDE BRIEF MEDICAL HISTORY (INJURIES, ACCIDENTS, SURGERIES, SIEZURES, ETC)

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ARE YOU CURRENTLY TAKING ANY MEDICATIONS? IF SO, PLEASE LIST BELOW. YES NO

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ARE YOU CURRENTLY RECEIVING OTHER ALTERNATIVE TREATMENTS? YES NO

HAVE YOU HAD A CRYSTAL HEALING SESSION BEFORE? YES NO

CRYSTAL HEALING INVOLVES GENTLE, APPROPRIATE, HANDS ON TECHNIQUE.

ARE YOU OKAY WITH LIGHT TOUCH? PLEASE CIRCLE. YES NO

DO YOU HAVE ANY DIFFICULTY LYING ON YOUR BACK DURING THE 60 MIN SESSION? YES NO

DO YOU FIND TIME TO RELAX OR MEDITATE? IF SO, HOW OFTEN? \_\_\_\_\_ YES NO

DO YOU FIND TIME TO EXERCISE? IF SO, HOW OFTEN PER WEEK? \_\_\_\_\_ YES NO

**HOW MANY HOURS A NIGHT DO YOU SLEEP? IS IT RESTFUL? IF NOT, PLEASE EXPLAIN:**

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**PLEASE RATE YOUR LEVEL OF STRESS REGARDING THE FOLLOWING: (0=NONE – 5=SEVERE)**

WORK \_\_\_\_\_ FAMILY \_\_\_\_\_ HEALTH \_\_\_\_\_ FINANCIAL \_\_\_\_\_

**CIRCLE THE AREAS WHERE YOU ARE SEEKING IMPROVEMENT:**

RELATIONSHIP	FAMILY	FRIENDS	CO-WORKERS/BOSS
FINANCES	WORK	SELF-ESTEEM	CONFIDENCE
ADDICTION	BAD HABIT	NEGATIVE THOUGHTS	REPEATING PATTERNS
DIRECTION	MOTIVATION	FOCUS	LIFE PURPOSE
ILLNESS	PHYSICAL PAIN	EMOTIONAL PAIN	PERSONALITY DISORDER
LETTING GO	CUTTING TIES	FORGIVENESS	ANGER/HATRED
SELF-HATRED	TRAUMA/SHOCK	PHYSICAL ABUSE	SEXUAL ABUSE
CHILDHOOD ISSUES	EATING DISORDER	ALCOHOLISM	HAUNTING MEMORIES
CLOSED OFF	DISCONNECTED	BITTER/COLD	EXHAUSTED

OTHER: \_\_\_\_\_

**WHAT IS YOUR GOAL FOR THIS SESSION? DO YOU HAVE A PARTICULAR AREA OF CONCERN YOU WOULD LIKE TO FOCUS ON TODAY?**

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**DO YOU HAVE ANY CONCERNS ABOUT TODAY'S CRYSTAL HEALING SESSION?**

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**HEALING CONSENT:**

I, (please print) \_\_\_\_\_, understand that the session I receive for any Crystal Healing services by Practitioner, Alison Summa are for the purpose of healing whether it be emotional, mental or physical or for the simple fact of healing the body, mind, and spirit. I also understand that Alison Summa does not diagnose illness, disease or any other physical or mental disorders. As such, Alison Summa also does not prescribe medical treatment or pharmaceuticals, nor does she perform any spinal manipulations or treat, prevent or cure any disease. I understand that the healings provided whether it be energy, sound, crystals, chakra balancing, and color therapy are not a substitute for medical treatment and that it is recommended that I see a physician for any physical ailment(s) that I may have. I have stated all my known medical condition(s) & take it upon myself to keep the practitioner updated in writing before any sessions on changes in my physical health. With that in mind, I agree to not hold the practitioner, Alison Summa nor Elements Healing Arts Center liable for any problems that may arise as a result of my session. I understand that there is a 24-hour cancellation policy. If I fail to show up for a scheduled appointment without proper 24-hour notice of cancellation, I will be subjected to payment. Payment is due at the time of the session(s) unless other arrangements have been made in advance. I also understand that I am responsible for payment if third party payment is not made.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_