POSSIBILITY WELLNESS

CONFIDENTIAL HEALING FORM
New Client Intake

www.possibilitywellness.com

PERSONAL INFORMATION

Name			Today's Date
E-mail			Date of Birth
Address			Telephone
City	State	Zip	Occupation

MEDICAL HISTORY

Do you take any medications? ☐ Yes ☐ No
If "Yes", specify:_____

Do you have a history of psychological disorder(s)? ☐ Yes ☐ No
If "Yes", specify:_____

Have you had any serious physical injuries? ☐ Yes ☐ No
If "Yes", specify: _____

Have you ever contracted a contagious disease? ☐ Yes ☐ No
If "Yes", specify:_____

Are you pregnant? ☐ Yes ☐ No

Are there any other aspects concerning your health you think we should know about? If "Yes", specify: ☐ Yes ☐ No
_____
_____

CLIENT INFORMATION

What are your current condition(s) / symptom(s)?:

How long have you had this condition(s) / symptom(s)? (Be Specific):

Comments / Other Relevant Medical History:

Check the box with the level of symptoms before and after the Pranic Healing session

	NONE	LIGHT			MODERATE				SEVERE		
	0	1	2	3	4	5	6	7	8	9	10
Before	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
After	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

DISCLAIMER: I, the recipient, understand that Pranic Healing is not intended to replace conventional medicine, but rather, to complement it. If symptoms persist, a medical professional should be consulted immediately. I hereby release the Pranic Healing provider person(s) and the Pranic Healing organization from any responsibility for the services I have received.

Client Name _____ Client Signature_____