Intake Consent Form

This Intake and Consent Form has been given to you to provide valuable information in assisting your healing. While sharing most information in this Form is voluntary, you must fill out the contact information immediately below, as well as sign and initial the consent at the end of this Form, for me to work with you. In addition to personal information, you are asked to disclose current and past medical history protected by the Health Insurance Portability and Accountability Act. As such, you have certain privacy rights in this information and, in compliance with the law, my HIPAA policy is available upon request. All information I obtain about you, whether written or shared verbally during session, and whether from you directly or another source, will be held in the utmost confidentiality. I will never share your information, medical or otherwise, without your express written consent and direction, unless otherwise required by law. While providing personal and medical information about you is entirely voluntary, without this information you may impair the progress of your sessions and potentially create risks to your health. If you have any questions about how to complete this form, how I use your information, or what your rights are regarding your information, please ask me before signing below.

Today's Date: _____

Client Full Name: _____

Date of Birth: _____

Email: _____

Preferred phone: _____

Alternate phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Person (Name & Phone Number):

_____

_____

Chakra Questionnaire

Root

1. Are you disorganized?
2. Do you eat, drink or smoke excessively as a means of escape?
3. Did you have some trauma, distress or difficulty between conception and the age of 7?
4. Do you feel fearful or anxious much of the time?
5. Are you low in energy and often feel weak, tired or just not well?
6. Do you have any physical problems in your legs, knees or feet?

Sacral

1. Do you have difficulty with touch – either being touched gently or being able to touch others?
2. Do you have problems with your kidneys, bladder or with retaining fluid?
3. Did you suffer distress or trauma between the ages of 7 and 14?
4. Do you feel that your general vitality and stamina are low?
5. Do you have difficulties with any part of your sexuality?
6. Do you feel your creativity is blocked or that you are not a creative person?

Solar Plexus

1. Do you have digestive problems, e.g. ulcers, heartburn or recurrent indigestion?
2. Do you have an aggressive nature?
3. Did you suffer distress or trauma between the ages of 14 and 21?
4. Are you easily influenced?
5. Do you sometimes feel powerless or have a low self-esteem?

Heart

1. Do you find it difficult to love or feel loved?
2. Are you intolerant, critical, or judgmental?
3. Do you feel exhausted and drained most of the time?
4. Are you impatient or the opposite, i.e. so patient and tolerant that people take advantage of you?
5. Do you have difficulty in saying you are sorry or in feeling forgiveness?

Throat

1. Do you have difficulty with general communication?
2. Do you have problems expressing yourself with speech, with making yourself understood clearly?
3. Do you have problems listening attentively to other people's point of view?
4. Do you have problems with throat infections, thyroid, ears or neck problems in general?
5. Are you shy, quiet, withdrawn?

Third Eye

1. Do you suffer from migraine, vision problems or headaches?
2. Are you unable to visualize your future?
3. Do you have nightmares?
4. Do you have a lack of imagination?
5. Do you have difficulty concentrating?

Crown

1. Do you feel separated from abundance and wholeness?
2. Do you have difficulty learning new things?
3. Do you feel uncertain or feel a lack of purpose?
4. Do you have a fear of death?
5. Are you overly intellectual?

MEDICAL CONDITIONS (CIRCLE ALL THAT APPLY):

Thyroid Disease	*Heart Problems*	*Joint/Muscle Pain*
Hypoglycemia	*Inner Ear Problems*	*Asthma*
Anemia	*Depression*	*Diabetes*
Allergies	*Addictions*	*Eating Disorders*
Anxiety Disorders	*Cancer*	*Claustrophobia*
Food Sensitivities	*Headaches*	

Other condition(s):

_____

_____

PERSONAL BACKGROUND

Are you pregnant? **Circle:** Yes/No

What is your previous experience with energy or alternative healing? Please share.

_____

_____

Have you ever undergone counseling? Please share.

_____

_____

Do you meditate? Please share.

_____

_____

What is your most volatile or vulnerable emotion?

_____

_____

What issue(s) do you want addressed during your healing session?

_____

_____

I feel the following emotions frequently:

_____

_____

I cannot feel the following emotions often/well:

_____

_____

How would you describe your spiritual beliefs, if any?

_____

_____

What are your current expectations of this plant and crystal healing?

_____

_____

Please check all that apply:

__ I have experienced alternative healing before
__ I have experienced a Reiki session before
__ I have had an energy balancing session before
__ I know about chakras
__ I have used holistic remedies before
__ I have a spiritual path that I am consciously following
__ I have experienced trauma
__ I have difficulty adjusting to new situations and or people
__ I am generally uncomfortable with touch
__ I am generally uncomfortable expressing myself
__ I love myself
__ I accept myself
__ I am comfortable expressing myself
__ I feel like I belong

Cancellation Policy

If for some reason, you are unable to make a session, you agree to give me a minimum of 24 hours advance notice. I will do my best to get you rescheduled in a reasonable amount of time, as my schedule permits. If you do not notify me 24 hours in advance of our session, it will be canceled and not rescheduled. Cancelled session fees are not refundable.

Thank you for your respect and consideration.

Consent and Release of Liability

Please read and agree to the following prior to signing below:

- I am requesting the service of Mackenzie Dickson of Mystical Medicinals, a practitioner, for the purpose of assisting me to access my own inner resources of healing energy so that I may learn to heal myself.
- All information I have provided in this Intake and Consent Form is accurate to the best of my knowledge
- I understand no guarantees or warranties are made to the effectiveness of crystal and plant energy healing, and take full responsibility for my expectations of the healing process.
- I have been given the opportunity to read my practitioner's HIPAA privacy policy, and have read (or waived my right to read) and understand its contents.
- I understand that, while certain medical options may be explained to me in the course of my healing, these explanations are in no way either a suggestion for medical treatment or any sort of prescription or medical directive, and do not constitute licensed medical advice. I waive any and all remedies I may have based on my own reliance on such information.
- I agree to pay my practitioner directly at the time of service or in advance
- I have read and agree to my practitioner's cancellation policy
- I release my practitioner, as well as any of his/her assistants or related business interests, from any and all liabilities or claims of any nature that may result my participation in crystal and plant healing, including but not limited to damages from my failure to pursue medical attention from a medical professional, for the exacerbation of any preexisting physical ailments I may have, and

By signing here, I agree to all these terms, and further bind my estate, heirs, and assigned to this release of liability.

_____ _____

Client Signature Date