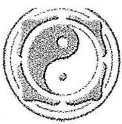

PRANIC HEALING® SESSION RECORD

CLIENT FORM

CONFIDENTIAL

TO HELP US SERVE YOU BETTER, PLEASE FILL OUT THE FORM BELOW:

Client Name: ______________________________ Date: ______________
First Name *Last Name*

Address: ____
Street *Apt#* *City* *State* *Zipcode*

Telephone: ______________________________ Age: ______________

Email: ____________________@____________________

CIRCLE WHAT IS APPROPRIATE:

1. Do you smoke? **yes** **no**
2. Do you drink alcoholic beverages? **yes** **no**
3. Do you have High blood pressure ? **yes** **no**
4. Are you pregnant or trying to get pregnant? **yes** **no**
5. Do you take any prescribed drugs/medications? **yes** **no** If Yes, Specify: ______________
6. Do you have history of contagious diseases? **yes** **no** If Yes, Specify: ______________
7. Do you have a history of psychological disorder? **yes** **no** If Yes, Specify: ______________
8. Do you have a history of serious physical injury? **yes** **no** If Yes, Specify: ______________

PURPOSE OF VISIT (SYMPTOMS, COMPLAINTS, PROBLEMS):

Rate your Pain/Discomfort Now: (*scale of 0 to 10*): 0 = No Pain 5 = Moderate Pain 10 = Unbearable: ________

Other Comments or Symptoms:

CLIENT'S COMMENTS AFTER THE SESSION:

Rate your Pain/Discomfort Now: (*scale of 0 to 10*): 0 = No Pain 5 = Moderate Pain 10 = Unbearable: ________

Other Comments or Symptoms:

I understand that Pranic Healing® is not meant to replace conventional medicine but rather to complement and enhance it. If symptoms persist, a medical professional is to be consulted. I hereby release the person(s) providing the Pranic Healing® Session and the U.S Pranic Healing Center from any liability as a result of the services and sessions I have received. I understand that this session record will be held confidential and may only be reviewed by the U.S. Pranic Healer Certification Board for the purpose of the Pranic Healer Certification Program.

Signature of Client______________________________ Date:______________