Client Profile Form

Confidential Client Information

Name: Today's Date:

Address: Date of Birth:

City, State, Zip:

Phone: Ok to text: yes no Ok to leave msg: yes no

Email: Join mailing list: yes no

Occupation:

Emergency Contact Info

Name: Relationship:

Contact numbers:

Doctors Info

Name of Doctor: Phone number:

Personal Health Info

What is your primary health compliant or symptom?

What are your secondary concerns?

www.curiositylifecoaching.com
curiositylifecoaching@gmail.com

Carrie C. Mead, M.S.

FB: curiositylifecoachingandreiki
IG: curiositylifecoachingandeiki
Pinterest: carriemeadlifecoach

Have you EVER had any of the following?

Anxiety….. □ Y □ N

Asthma/Breathing Problems......................... □ Y □ N

Bleeding/Clotting Disorder........................... □ Y □ N

Blood Transfusion .... □ Y □ N

Cancer.. □ Y □ N

Diabetes... □ Y □ N

Depression... □ Y □ N

High Blood Pressure…...................................... □ Y □ N

Heart Disease/Disorder ....□ Y □ N

Liver Disease ....□ Y □ N

Pain Disorder.. □ Y □ N

Pulmonary Embolism/DVT.............................□ Y □ N

Skin Disorders ....□ Y □ N

Stroke..□ Y □ N

Urinary/Kidney Disorder.................................□ Y □ N

Gynecological Issues…………………….. □ Y □ N

Arthritis... □ Y □ N

Blood Pressure Disorder............................... □ Y □ N

Bowel/Stomach Problems............................ □ Y □ N

Cholesterol Disorder .... □ Y □ N

Eye Disorder (i.e. Glaucoma, cataract)....... □ Y □ N

Fatigue (Chronic) or Insomnia.................... □ Y □ N

Low Blood Pressure.. □ Y □ N

Lung Disorder... □ Y □ N

Neurological Disorder/ Headaches ……... □ Y □ N

Psychiatric Disorder/Illness..........................□ Y □ N

Spinal Cord / Neck Injury ....□ Y □ N

Seizure or Epilepsy ....□ Y □ N

Thyroid Disorder ....□ Y □ N

Other:

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list any current medications and supplements you are taking and reason:

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Below, please provide details on all past surgeries and procedures:

Procedure	Hospitalization Date	Complication

Do you drink alcohol? yes no

How much, how often and is this a concern to you or others?

Do you smoke cigarettes or vape? yes no

How much, how often and is this a concern to you or others?

Do you use or abuse street drugs or pain medications? yes no

How much, how often and is this a concern to you or others?

Please list all allergies (including essential oils and Almond oil):

Please provide details of your exercise and self-care habits:

Please provide details of your sleep habits:

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Reiki and Energy Work Liability Release Form.

I understand that if I experience any pain or discomfort during my session(s), I will immediately inform the practitioner so that adjustments may be made to my level of comfort. I further understand that Reiki and energy work are not a substitute for medical examinations, diagnoses, treatment, medications, or mental health therapy and that I will see a qualified professional for any mental or physical ailment that I experience. I understand that any feedback or conversation about health concerns should not be considered as medical advice. I also understand that Reiki practitioners are not qualified to perform manual manipulation of muscle tissue or any form of massage. I acknowledge that during the Reiki session the practitioner will lightly touch my body and head while I am laying comfortably and fully clothed, and, I agree to this form of light, clothed, touch. I acknowledge that I have been honest about my medical history and that I have expressed any concerns to the practitioner before my session. I agree to keep the practitioner updated on any changes to my medical history and I understand that there will be no liability on the practitioner's part should I forget to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and, I will be liable for full payment of the scheduled appointment. I acknowledge that services will only be performed upon completion of this form.

Client signature: Date:

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