Integrative Balance Crystal Therapies

Client Consultation Form

**Full name** ……………………………………………………………….. **Date of birth** …………………………………… **Address** ………………………………………………………………………………………………………………………………. **Contact number** …………………………………… **Email address** …………………………………………………….. **GP name and address** …………………………………………………………………………………………………………. **General/Medical information**

Please list bellow all your diagnosed conditions/diseases

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Have you had recent surgery (less than 6 months)

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Are you under medical/specialist investigation?

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Please list bellow all your prescribed medication

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**Do you smoke/vape?** ………………………… **Do you consume alcohol?** ……………………………………

Do you consume any non-prescription drugs?

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**Emotional and Mental Attitude General Information**

We carry in our bodies the frequencies of **worry**, **fear**, **anger**, **sadness,** and **pre-tense.** Please rate **1-10** the level of those frequencies in your daily routine.

**Worry:** Discontent **Fear:** Insecure

Concerned Anxious

Restlessness Terrified

**Anger:** Irritated **Sadness:** Disappointed Frustrated Upset

Annoyed Grieving

Explosive

**Pre-Tense:** Coping

Trapped Depressed

Alternative therapies you are currently undertaking

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What are your expectations from Crystal Therapies

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Client declaration:

I declare that the information I have given is correct and that I have not withheld any information regarding my health. I acknowledge that there is a possibility of developing minor, temporary detox sensations following treatment.

**Client signature:** …………………………………………………………………… **Date:** ……………………...........