PRANIC HEALING® PRO-BONO RECORD

CLIENT FORM

CONFIDENTIAL

PRO_BONO CLINIC

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

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

Address: ____
Street *Apt#* *City* *State* *Zip Code*

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: ______________

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

Other Comments

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Other Comments

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:______________

Healers Name

Healer Email