Muse Wellness Company

Live brilliantly from head to soul!

Client Assessment

Name ____

Address ____

City ______________________________ State ______________ Zip ________________

Telephone _________________________ Email _________________________________

Preferred form of contact ____

Emergency Contact (name & number) ____

Primary Care Physician (Name, Telephone number, Date of last exam)

____

D.O.B. ________________________ Age _____________ Gender ____________________

Occupation ____

Number of Hours Worked per Week ________ Level of Satisfaction (scale 1-10) ____________

Relationship Status ____

Children? (Names & Ages) ____

Current Weight _________ Height _________ What time do you wake up? ______________

What time do you go to bed? ___________ What time do you fall asleep? ________________

Do you feel rested when you wake up? ____

Exercise (types/how often?) ____

____

Current Health Concerns ____

____

List any symptoms you experience in your body on any given day (list in the order they first occurred): ____

____

Current Medication (Please include topical, oral, and reason for taking)

____

____

____

Vitamins/Supplements ____

____

Allergies/Sensitivities (Please include food, medicine, and products)

____

Recent Pregnancy? _______________ Birth Control Method_______________________________

Personal History of (yes/no): _______Diabetes/Pre-Diabetes _______ Cancer _____ Heart Problems_______ Thyroid Problems _______ Eczema _______ Rosacea ______ Psoriasis ______ Acne ______Constipation _______ Diarrhea/Loose Stool ________ Digestive Issues (IBS, Crohn's, Leaky Gut, Acid Reflux, etc.)

Past Surgeries/Medical Procedures (Please list year and reason):

____

____

Family Medical History (Please list the condition and the family member who has it. Ex.: cancer/maternal grandmother):

____

____

____

Do you smoke? ____ How many/how often? ____

Do you drink alcohol? ____ How many drinks/How often? ________________________________

What is your relationship with food? ____

Do you cook? _____ How many meals per week? 1-3_____ 3-5_____ 5-7_____ 7-10_____ 10+_____

How many meals do you eat at home? Breakfast __________ Lunch __________ Dinner _________

How many times per week do eat out? ________ How do you rate your diet? (Scale 1-10)

____

Foods typically eaten at each meal: (Please list time eaten and how much)

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Dessert: ____

How much water do you drink daily? ____

List any food cravings? ____

Other (non-food) cravings? ____

____

How happy are you with life in general? (Scale 1-10) _______________________________________

If you could change one thing about your life/health/look, what would it be? ________________

____

Is there anything else you would like to share? ____

____

____

____

FOR ESTHETIC CLIENTS ONLY:

Primary Skin Concerns: ____

____

Current Skincare Routine (Please list all products currently using): ______________________

____

Skincare Treatments History: (Check all that apply)

_____ Waxing/Hair Removal _____ Chemical Peels ____Injections ____Microdermabrasion

____ Accutane _____ Laser Treatments ______ Cosmetic Surgery ______Other (Please list):

____

Do you Tan (sun or tanning salon)? _____ How long? ___________ How often? _____________

Do you receive regular facial treatments? Yes ____ No ____

If yes, what was the date of your last facial? ___________

FOR REIKI CLIENTS ONLY:

Have you ever had a Reiki session before? Yes ____ No ____

If yes, for what purpose? (General wellness, stress reduction, etc.) ________________________

____

What do you hope to accomplish with this Reiki session? (Mark all that apply.)

Relaxation ____ Stress Reduction ____ Pain Management ____ Other ___________________

What are your common areas of pain or tension? ____________________________________

List any areas you would like the practitioner to focus on during your session: ______________

____

Are you sensitive to fragrances or perfumes? Yes ____ No ____

What type of session would you prefer? Hands-on ____ Hands-off ____

Thank you for completing this assessment form.

Client Signature (parent/guardian if client is a minor) ___________________________________

Date: __________________ Relationship to client _______________________________________