Ether's Ember Crystal Healing Client Intake Form

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name & Number:

_____

Referred By (if any): _____

Consent & Client Agreement

Are you 18 years of age or older?
☐ Yes ☐ No (If under 18, parent/guardian consent is required.)

Health & Sensitivities

Do you have any **known allergies or sensitivities** (scents, oils, herbs, smoke, etc.)?
☐ Yes ☐ No

If yes, please list: _____

Are you currently experiencing any of the following? (Check all that apply)
☐ Chronic pain
☐ Recent surgery
☐ Pregnancy
☐ Breathing issues/asthma
☐ PTSD or trauma-related sensitivity
☐ Sensitivity to touch or personal space
☐ Sensory processing challenges
☐ Other (please explain): _____

Are there any **specific physical needs** I should be aware of for your comfort

_____

Energetic & Emotional Insights

Please answer honestly and openly. This helps me co-create a meaningful session tailored to your current energetic needs.

What brings you in for this session?

What is your **intention or desired outcome** from today's session?
(Ex: clarity, emotional release, chakra balancing, clearing, grief support, grounding, etc.)

Have you received a crystal healing or energy session before?
☐ Yes ☐ No
If yes, when and what was your experience like?

Chakra & Balance Check-In

Check any areas you currently feel drawn to explore or support:

☐ Root Chakra – Feeling safe, stable, secure

☐ Sacral Chakra – Creativity, emotions, sensuality

☐ Solar Plexus – Confidence, power, boundaries

☐ Heart Chakra – Love, grief, forgiveness, connection

☐ Throat Chakra – Communication, truth, expression

☐ Third Eye Chakra – Intuition, clarity, overthinking

☐ Crown Chakra – Connection to spirit, meaning, trust

Legal Disclaimer & Informed Consent

Crystal healing and energy work are gentle, non-invasive, complementary practices intended to support your energetic, emotional, and spiritual well-being. These services are **not a substitute for licensed medical, psychological, or therapeutic care**. No guarantees are made regarding outcomes.

If you have a medical or psychological condition, or a health concern of any kind, please consult with your licensed health care provider before beginning any alternative wellness practice.

By signing below, you acknowledge and agree to the following:

- I understand that this session is a **holistic wellness practice** and not a medical treatment.
- I affirm that I am voluntarily receiving services and take full responsibility for my own health and well-being.
- I understand that results vary and that this is not a substitute for any form of licensed or regulated healthcare.
- I release the practitioner and their practice from any and all liability, including **accidental injury, allergic reaction, emotional discomfort, or other outcomes** that may occur during or after the session.
- I understand that I may stop or pause the session at any time.
- I agree to inform the practitioner of any allergies, physical conditions, or sensitivities that may affect the session.

Name: _____

Signature: _____

Date: _____