**Muse Wellness Company**

Live brilliantly from head to soul!

**Client Assessment**

**Name:** Click here to enter text.

**Address:** Click here to enter text.

**City:** Click here to enter text. **State:** Click here to enter text. **Zip:** Click here to enter text.

**Telephone:** Click here to enter text. **Email:** Click here to enter text.

**Preferred form of contact:** Click here to enter text.

**Emergency Contact: (Click here to enter n**ame & number)

**Primary Care Physician:** Click here to enter name, telephone number, & date of last exam.

**D.O.B.:** Click here to enter a date. **Age:** Click here to enter text. **Gender:** Click here to enter text.

**Occupation:** Click here to enter text.

**Number of Hours Worked per Week:** Click here to enter text.

**Level of Satisfaction:** Click here to enter scale 1-10.

**Relationship Status:** Click here to enter text.

**Children?** [ ]  **Yes** [ ]  **No** Click here to enter names & ages.

**Current Weight:** Click here to enter text. **Height:** Click here to enter text.

**What time do you wake up?** Click here to enter text.

**What time do you go to bed?** Click here to enter text.

**What time do you fall asleep?** Click here to enter text.

**Do you feel rested when you wake up?** Click here to enter text.

**Exercise (types/how often?)** Click here to enter text.

**Current Health Concerns** Click here to enter text.

**List any symptoms you experience in your body on any given day (list in the order they first occurred):** Click here to enter text.

**Current Medication:** Click here to enter text. Please include topical, oral, and reason for taking.

**Vitamins/Supplements:** Click here to enter text.

**Allergies/Sensitivities** Click here to enter text. Please include food, medicine, and products.

**Recent Pregnancy?** [ ]  **Yes** [ ]  **No**

**Birth Control Method:** Click here to enter text.

**Personal Medical History: (Mark all that apply.)**

[ ]  **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.)**

[ ]  **Other** Click here to enter text.

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

Click here to enter text.

**Family Medical History (Please list the condition and the family member who has it. Ex.: cancer/maternal grandmother):** Click here to enter text.

**Do you smoke?** [ ]  **Yes** [ ]  **No** If yes, click here to enter how many/how often?

**Do you drink alcohol?** [ ]  **Yes** [ ]  **No** If yes, click here to enter how many drinks/how often?

**What is your relationship with food?** Click here to enter text.

**Do you cook?** [ ]  **Yes** [ ]  **No**

**How many meals per week?** [ ]  **1-3** [ ]  **3-5** [ ]  **5-7** [ ]  **7-10** [ ]  **10+**

**How many meals do you eat at home?**

**Breakfast:** Click here to enter amount.

**Lunch** Click here to enter amount.

**Dinner** Click here to enter amount.

**How many times per week do eat out?** Click here to enter amount.

**How do you rate your diet?** Click here to enter scale 1-10.

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

 **Breakfast:** Click here to enter text.

 **Lunch:** Click here to enter text.

 **Dinner:** Click here to enter text.

 **Snacks:** Click here to enter text.

 **Dessert:** Click here to enter text.

**How much water do you drink daily?** Click here to enter amount.

**List any food cravings?** Click here to enter text.

**Other (non-food) cravings?** Click here to enter text.

**How happy are you with life in general?** Click here to enter scale 1-10.

**If you could change one thing about your life/health/look, what would it be?** Click here to enter text.

**Is there anything else you would like to share?** Click here to enter text.

**FOR ESTHETIC CLIENTS ONLY:**

**Primary Skin Concerns:** Click here to enter text.

**Current Skincare Routine:** Click here to list all products you are currently using.

**Skincare Treatments History: (Mark all that apply.)**

[ ]  **Waxing/Hair Removal** [ ]  **Chemical Peels** [ ]  **Injections** [ ]  **Microdermabrasion**

[ ]  **Accutane** [ ]  **Laser Treatments** [ ]  **Cosmetic Surgery** [ ]  **Other** Click here to list.

**Do you Tan (sun or tanning salon)?** [ ]  **Yes** [ ]  **No** Click here to enter how long/how often?

**Do you receive regular facial treatments?** [ ]  **Yes** [ ]  **No**

If yes, what was the date of your last facial? Click here to enter a date.

**FOR REIKI CLIENTS ONLY:**

**Have you ever had a Reiki session before?** [ ]  **Yes** [ ]  **No**

**If yes, for what purpose? (General wellness, stress reduction, etc.)** Click here to enter text.

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

[ ]  **Relaxation** [ ]  **Stress Reduction** [ ]  **Pain Management** [ ]  **Other** Click here to explain.

**What are your common areas of pain or tension?** Click here to enter text.

**List any areas you would like the practitioner to focus on during your session:** Click here to list focal points.

 **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.***

**Name of person completing assessment (parent/guardian if client is a minor):** Click here to enter text.

**Relationship to client:** Click here to enter text.

**Date:** Click here to enter a date.