

# DONNA SWEENEY

## energy therapy Client Information Form

Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Person to contact in an emergency \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Have you ever had a Reiki or IET® session before?  Yes  No

What would you like to accomplish with this Energy Therapy session?

Relaxation  Stress Reduction  Pain Reduction  Other - please explain

\_\_\_\_\_

\_\_\_\_\_

Would you like to state an intention for yourself with this Energy Therapy session?

\_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_