Reiki Intake

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Confirmation: E-mail / Phone / Text

DOB (D/M/Y): \_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ How do you identify: \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AHC # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**X all apply: Musculo-Skeletal System Reproductive System Female:**

☐Neck Pain ☐ Pregnant

**Cardiovascular** ☐Back Pain Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

☐High Blood Pressure ☐Hip Pain ☐C Section/Complications?

☐Low Blood Pressure ☐Shoulder/Arm/Hand Pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Congestive Heart Failure ☐Leg & Foot Pain ☐Irregular Menstruation

☐Heart Attack ☐Headaches/Migraines ☐Menstruation Problems

☐Phlebitis/Varicose Veins ☐Herniated Disc

☐Stroke/CVA ☐Joint Stiffness/Swelling **Other**:

☐Pacemaker ☐Spasms/Cramps ☐Cancer

 ☐Broken/Fractures Bones Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory**: When: \_\_\_\_\_\_\_ Pins/Wires? ☐Depression

☐Chronic Cough ☐Strains/Sprains ☐Hearing Problems

☐Shortness Of Breath ☐Jaw Pain/TMJ ☐Vision Problems

☐Bronchitis ☐Tendonitis (Tennis/Golfers) ☐Diabetes

☐Asthma ☐ Bursitis Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Emphysema ☐Arthritis Type: \_\_\_\_\_\_\_ ☐HIV/Hepatitis A/B/C

☐Chronic Obstructive ☐Osteoporosis ☐Herpes/Cold Sores

☐Pulmonary Disease ☐Scoliosis ☐Digestive Conditions

 ☐Whiplash ☐Ulcers

**Nervous System**: ☐MVA When: \_\_\_\_\_\_\_\_\_ ☐Sinus Problems

☐Numbness/Tingling ☐Fibromyalgia ☐Tuberculosis

☐Pinched Nerve ☐Chest/Ribs/Abdominal Pain ☐Tinnitus (Ear Ringing)

☐Insomnia ☐Anxiety/Stress

☐Chronic Fatigue **Skin Conditions**

☐Cerebral Palsy ☐Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_ Have you received massage

☐Epilepsy/Seizures ☐Sensitivities: \_\_\_\_\_\_\_\_\_\_\_ therapy before:

☐Multiple Sclerosis ☐Rashes Yes / No? When?

☐Muscular Dystrophy ☐Athletes Foot \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Parkinson's Disease ☐Hemophilia/Anemia

 ☐ Bruise Easily

 ☐Psoriasis

 ☐Warts

Injuries or Surgeries within the last 5 years:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Mark areas of discomfort:

Are you currently taking any medications or Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any medical conditions not listed above? If yes, please describe: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you comfortable with a light touch during reiki sessions? Yes / No

(Please indicate if you prefer hands-off treatment) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any additional comments or questions before we begin your session?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT**

I understand that Reiki is a simple, gentle, hands-on energy technique that is used for

stress reduction and relaxation. I understand that Reiki practitioners do not diagnose

conditions nor do they prescribe or perform medical treatment. I understand that Reiki

does not take the place of medical or psychological care. I understand that Reiki can

complement any medical or psychological care I may be receiving.

I also understand that the body has the ability to heal itself and to do so, complete

relaxation is often beneficial. I acknowledge that long term imbalances in the body

sometimes require multiple sessions in order to facilitate the level of relaxation needed

by the body to heal itself.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If client is a minor a parent or guardian must sign)

Privacy Notice:

No information about any client will be discussed or shared with any third party without

written consent of the client or parent/guardian if the client is under 18.