

Welcome. I would like to make your appointment as pleasant and comfortable as possible. If you have any questions regarding your session please let me know.

Name _____ Contact # _____ email _____

Address _____ City _____ State/Zip _____

Date of birth _____ Age _____ M/F _____ Occupation _____

Have you ever received reiki therapy? Y/N _____ If so how was that experience? _____

Are you currently taking any medications? Y/N _____ please describe _____

Are you currently seeing a health care professional? Y/N _____ if yes list reason? _____

can I contact them? Y/N _____ Contact information _____

Please review this list and check those conditions that have affected your health recently or in the past.

- | | |
|-----------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> depression, panic disorder, others psychiatric condition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> headaches |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> heart conditions |
| <input type="checkbox"/> Broken/dislocated bones | <input type="checkbox"/> back problems |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> muscle strain/sprain |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> Auto-immune condition* | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> Hepatitis (A, B, C, other) | <input type="checkbox"/> seizures |
| <input type="checkbox"/> Skin conditions | <input type="checkbox"/> whiplash |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> chemical dependency (alcohol, drugs) |
| <input type="checkbox"/> Surgery | |
| <input type="checkbox"/> TMJ disorder | (* HIV/AIDS, fibromyalgia, chronic fatigue, lupus, etc) |

If any of the above needs to be detailed or if there is anything else you would like to share please do so: _____

Are you wearing: _____contact lenses_____hearing aid_____ hairpiece

Do you have any of the following today:

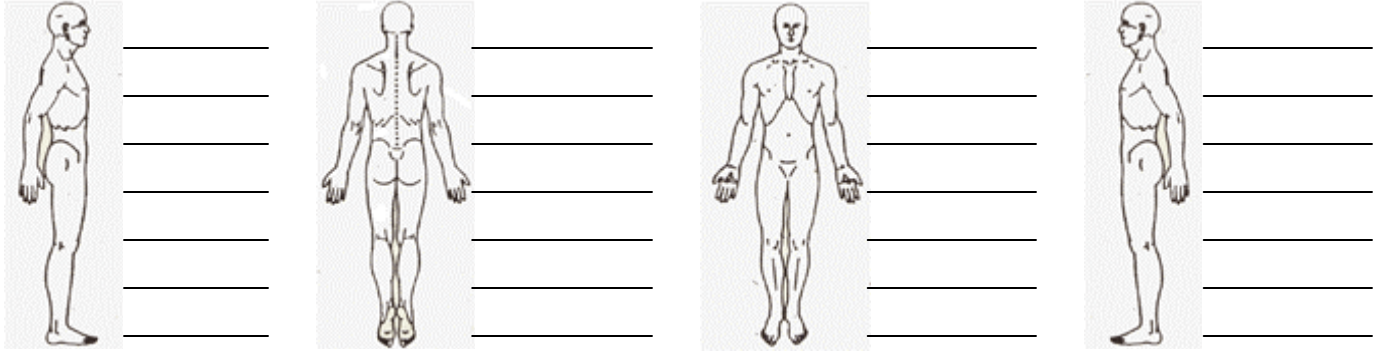
Skin rash cold/flu open cuts severe pain anything contagious injuries/bruises

Do you have any allergies to:

Medications foods environmental allergens (dust, pollen, fragrances) skin care products

Have you taken medications or alcohol in the past 6 hours? Y/N _____ If you have checked any of the above please give details: _____

Please indicate with an X any areas in which you are feeling discomfort. If possible please describe what your experiencing :



What are you goals/expectations for this therapy session? _____

How did you find out about my services? _____

In case of emergency who do we notify? Name _____ Phone _____

**The following sometimes occurs during reiki.
 They are normal responses to relaxation.
 Permit your body to express what it needs to:**

- The need to move or change position ❖ sighing, yawning, change in breathing ❖ stomach gurgling ❖ emotional feelings/expression
- Bathroom breaks ❖ movement of intestinal gas ❖ energy shifts ❖ falling asleep ❖ memories

Please read the following information and sign below:

1. I understand that although reiki can be very therapeutic and relaxing it is not a substitute for medical examination diagnosis and treatment.
2. This is a therapeutic session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. I affirm that I have answered all the questions pertaining to medical conditions truthfully.
4. I agree to keep the therapist updated as to any changes in my medical profile prior to any future sessions and understand that there shall be no liability on the therapists part should I fail to do so.
5. Information exchanged during my session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.
6. Our time together is precious and I agree to cancel 24 hours in advance unless there is an emergency. If I miss an appointment I agree to pay the full appointment fee.
7. The therapist reserves the right to refuse service to anyone for any reason.

Client Signature _____

Date _____

Therapist Signature _____

Date _____