eternal bliss

HOLISTIC HEALTH

Reiki Intake Form

Name: _____

Date of birth: _____ Date of visit: _____

Phone: _____ Email: _____

Address: _____

Emergency Contact: _____ Emergency Phone: _____

Relationship: _____ Referring Person: _____

The following information will be used to help plan safe and effective Reiki sessions. Answer the questions to the best of your knowledge

Have you ever had Reiki before Yes No

If yes how often do you receive Reiki _____

If yes please briefly describe the desired outcome you hoped for from your previous Reiki sessions and what your actual experience was

_____

_____

Do you have any difficulty lying on your front or back? Yes No

If yes please explain _____

_____

What is your goal for today's Reiki session? (Please circle all that apply)

Relaxation General Wellness Increased vitality Stress Reduction

Pain Reduction Improved Sleep

Other: _____

Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think it has affected your health? (Please circle all that apply)

Muscle tension Anxiety Insomnia Irritability

Headaches/migraine

Other: _____

Is there a particular area of your body where you are experiencing tension, stiffness, pain or other discomfort?

Yes No

If yes, please explain _____

_____

Do you have any allergies or sensitivities? Yes No

If yes please explain: _____

_____

Are you currently under medical supervision? Yes No

If yes, please explain _____

_____

Are you currently taking any medication? Yes No

If yes, please explain _____

_____

_____

Is there anything else about your health history that you think would be useful for your Reiki therapist to know in order to plan a safe and effective Reiki session for you?

_____

_____

_____

Consent Form

I, _____ (Print Name) understand that the Reiki I receive is provided for the basic purpose of relaxation and relief of tension and stress. If I experience any pain or discomfort during the session. I will immediately inform the therapist so that adjustments can be made for my level of comfort. I further understand that Reiki should not be constructed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any physical or mental ailment that I am aware of. I understand the Reiki therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be constructed as such. I affirm that I stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so

Signature of client _____ Date: _____

Signature of Reiki Therapist _____ Date: _____

Signature of parent _____ Date: _____
(If client is under the age of 18)