Reiki

REIKI THERAPY INTAKE FORM

Name _____ Birthday _____

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Phone #_____ Email: _____

Emergency Contact Name & Number: _____

How did you hear about us?_____

Have you ever had a Reiki session before? Yes ☐ No ☐

If yes, date of last session: _____

What is your goal for this Reiki session?_____

Please list any specific area(s) of concern: _____

Do you have any difficulty lying on your back for the entire session? Yes ☐ No ☐

Do you have any sensitivity to perfumes or fragrances? Yes ☐ No ☐

Are your feet sensitive to touch? Yes ☐ No ☐

Are you comfortable with a light touch during a Reiki session? Yes ☐ No ☐

MEDICAL HISTORY:

Are you pregnant? Yes ☐ No ☐

If yes, how far along and are there any concerns? : _____

Do you suffer from chronic pain? Yes ☐ No ☐

If yes, what makes it feel better or worse? _____

Are you taking any medications? Yes ☐ No ☐

If yes, please list: _____

Have you had any orthopedic injuries? Yes ☐ No ☐

If yes, where?: _____

Please check if any of the following conditions apply to you:

Fibromyalgia ☐ Joint Replacement ☐ Diabetes ☐ Stroke ☐ Heart Attack ☐

Sprains/Strains ☐ Headaches/Migraines ☐ Arthritis ☐ Numbness ☐ Kidney Dysfunction ☐

Cancer ☐ High/Low Blood Pressure ☐ Blood Clots ☐ Depression ☐ Anxiety ☐

With my signature below, I confirm that I have accurately completed the above information to the best of my knowledge. I agree to notify my Reiki Practitioner of any other relevant information that may affect my treatment, including any changes to the information above. I agree to communicate with my Reiki Practitioner about any pain or discomfort experienced during or after the procedure. I release my Reiki Practitioner of any and all liability of injury or damages that may arise because I have not represented my medical history accurately.

Printed Client's Name	Signature	Date
_____	_____	_____
Therapist's Name	**Signature**	**Date**
_____	_____	_____

Reiki

REIKI THERAPY CONSENT FORM

__ I confirm I am at least 18 years of age, or have parental / guardian permission.

__ I have elected, by my own decision, to have a Reiki therapy session.

__ I confirm that I am not under the influence of recreational drugs or alcohol.

__ The procedure, including the process and objective, has been explained to me before undergoing Reiki.

__ I understand that Reiki is a simple, gentle, hands-on energy technique used for stress reduction and relaxation.

__ I understand that a Reiki session is not a substitute for medical or psychological diagnosis and treatment. I also understand that it is not massage therapy.

__ I understand that it is recommeded that I see a licensed physcian or licensed health care professional for any physical or psychological ailment I may have.

__ I understand that participation is voluntary and that at any time I may choose to end my participation.

__ 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.

__ I have been given the opportunity to ask questions regarding any benefits, risks, or possible complications of the procedure.

__ I have followed all pre-treatment care instructions as they have been explained to me.

__ I understand all aftercare procedures for Reiki as they've been explained, and I intend to adhere to the instructions given to me.

__ I understand that it is important to provide feedback during my treatment, and will inform my Reiki Practitioner of any pain or discomfort during the session.

With my signature below, I confirm that I have read fully and understand the information in this consent form and all details included. I have provided an accurate account of my medical history including any medications I take or intend to take, and any medical procedures I intend to undergo. By signing below, I agree to accept all and full responsibility for any risks, injuries, damages, or side effects that may occur as part of the procedure. I will not hold my Reiki Practitioner (recorded below) responsible for any conditions present, but not disclosed at the time of treatment, that may affect the treatment.

Printed Client's Name	Signature	Date
_____	_____	_____
Therapist's Name	Signature	Date
_____	_____	_____