

Reiki Intake Form

Restore Health Therapeutic Massage

Confidential Client Information-Energy Healing Therapies

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

ZIP: _____ Phone Number: _____

Email Address: _____

How would you like to receive appointment reminders? -Phone Call - Phone Text 1 None* *Please note that failure to keep your appointment or cancel within 24 hours may result in additional fees.

Current Occupation/Employer:

How did you hear about us? _____

Have you ever received an energy healing therapy session? – Yes - No How recently?

_____ What type of session did you receive? 1 Reiki 1 Sound Vibrational Tuning Form Therapy 1

Crystal Therapy 1 Other, please explain: _____

What do you hope for, and what are your expectations from this healing today:

The following required information must be completed in its entirety, honestly and to the best of your knowledge:

What, if any, medical conditions are you currently receiving treatment for?

Please list all medications (over-the-counter and prescribed) and supplements that you are currently taking:

Please list all allergies or sensitivities, including smells:

Can you comfortably lie on your back for an extended period of time? - Yes - No

Are you currently pregnant? 1 Yes 1 No

Do you have a pacemaker? - Yes - No

By providing my signature below, I confirm that the information recorded above is complete, accurate, and honest to the best of my knowledge. I understand that energy healing therapies are not a replacement for medical treatment, and that the therapist may only perform treatments within his or her scope of practice and level of comfort. Anything said during this session shall not be regarded as medical advice, treatment, diagnosis, or prescription. I understand that the therapist may refuse service at any time for any reason, and that clients may be referred to a medical professional if the therapist feels this is necessary. I understand that it is my responsibility to inform the therapist of any changes to my medical health profile and that the therapist will not be held liable for anything resulting from my failure to do so. I agree that I have been given sufficient opportunity to ask questions and make specific requests in order to make my treatment time as comfortable as possible. I have also read and will abide by all policies and client expectations that may be listed separately from this document.

Client Signature: _____ Date: _____