

NEW CLIENT INTAKE FORM (Reiki)

GENERAL INFORMATION

Full Name: _____
Name you prefer: _____ Pronoun Preference: _____
Age: _____ Date of Birth: _____

CONTACT INFORMATION

Street Address: _____ Suite or Apt. #: _____
City: _____ State: _____ Zip Code: _____ May I send mail here? Yes No
Mailing Address (if different): _____
City: _____ State: _____ Zip Code: _____ May I send mail here? Yes No
Email Address: _____ May I send a message here? Yes No
Cell Phone: (____) _____ May I leave a message here? Yes No
Work Phone: (____) _____ May I leave a message here? Yes No

PRESENTING ISSUES

Please share your reasons for seeking Reiki treatments: _____

Have you ever had a Reiki treatment before? _____

REFERRAL SOURCE

How were you referred to me? Online Directory Website Friend/Family Other
Name of person/directory/other: _____
May I have your permission to thank this person for the referral? Yes No N/A

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: (____) _____

Address: _____ City: _____ Zip: _____

Are you currently receiving medical treatment? Yes No

If Yes, please specify: _____

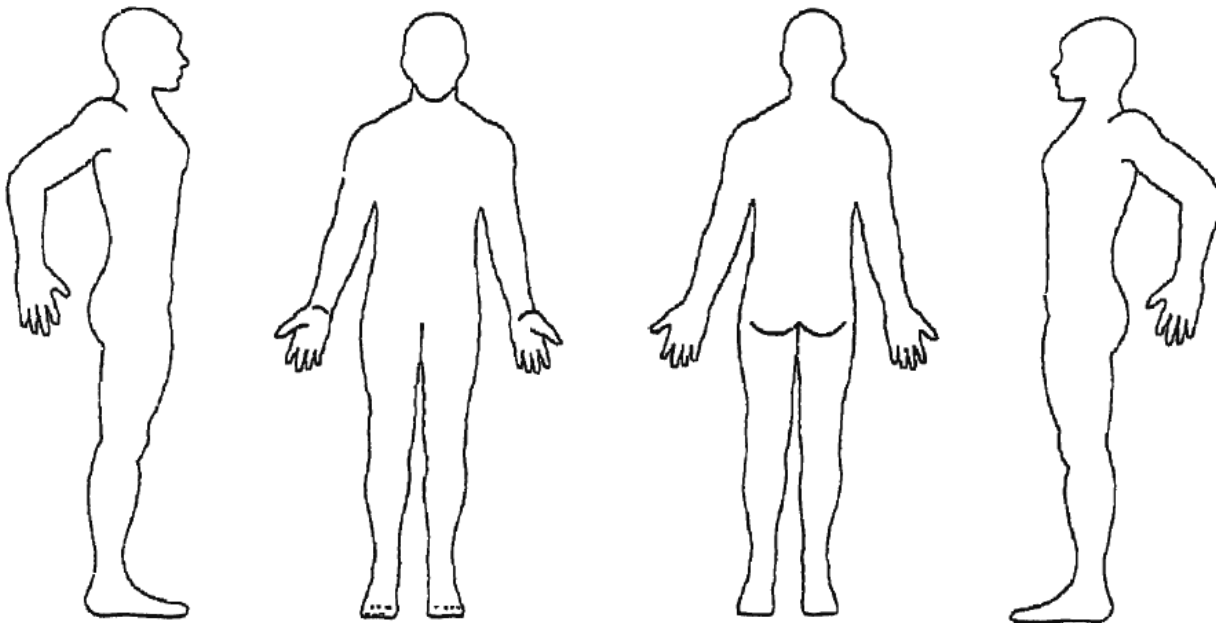
Do you have any skin conditions or allergies? Yes No

If Yes, please specify: _____

List any previous conditions, illnesses, surgeries, hospitalizations, or injuries you've had:

Current medications and/or supplements: _____

On the figures below, please indicate areas of stress, discomfort, tension, pain, or injury:



TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my personal information is kept confidential, unless I provide written consent for my information to be disclosed.

Signed: _____ Date: _____