a RAINBOW of REIKI 恵

REIKI INTAKE & INFORMATION FORM

NAME _____ TODAY'S DATE _____

ADDRESS _____ DOB _____

HOME PHONE _____ CELL PHONE _____

EMAIL _____ OCCUPATION _____

REFERRED BY _____

Relationship status?

How do you feel about your situation/relationship?

Do you have children? If so, list gender and age.

What are you hoping to achieve with the help of reiki?

Have you ever had any energy work in the past? (ex: reflexology, acupuncture, massage, etc). If so, what was your experience like?

Are you currently under a doctor or therapist's care? If so, for what condition?

How often do you meditate? _____ How often do you exercise? _____

What do you do to relax and when you have down time?

How much of the following do you consume?

_____ 8 oz cup of caffeine (coffee, tea, soda) per day?

_____ 8 oz glasses of water per day?

_____ Percentage of carbs and/or sugar per day? (cereal, breads, candy, pasta)?

_____ Cigarettes per day?

_____ Alcoholic beverages per week

How many hours of sleep per night? _____ How well do you sleep?

Do you have a lot of stress, sadness or pressure in your life?

Please list any medications you are currently taking and the reason for the medication.

Please check any of the below conditions which apply. Reiki is not designed to solely treat any of the below conditions, however, along with medical treatment, they may aid in the healing process.

____ Surgery (list below)	____ Pregnant/infertility	____Blood clots
____Irregular menstrual/PMS	____ Stroke	____Heart attack
____High/Low blood pressure	____Diabetes	____Numbness/tingling in body
____Weakness/Coldness in extremities	____Asthma	____Trouble breathing
____Tightness/sore throat	____Allergies (list below)	____ Joint pain
____Cancer: past/current	____Bipolar	____ADD
____Depression/sadness	____Tiredness/fatigue	____ Anxiety: acute/mild
____Headache/migraines	____ Neck stiffness/ tightness/pain	____ Back pain (lower/mid/upper)

Do you have other mental or physical conditions? If so where and please explain:

In the past few years what major life altering events have occurred and when? (Births, deaths, marriages, divorce, new career or job, move)

Other than the pelvic and/or breasts, are there any other areas of the body which you do NOT wish to have touched?

This form is confidential between the Reiki Practitioner and Client. I understand that Reiki sessions are for the purpose of reducing stress and increasing relaxation. I also understand that a session of Reiki is not a substitute for psychological or mental diagnosis and/or treatment for such. Furthermore, a Reiki practitioner does not diagnose conditions nor prescribe, perform or interfere with any medical treatment or licensed medical professional. It is recommended that I see a licensed health care professional for any psychological or physical ailment I have. By signing my name below, I am demonstrating my understanding of the above information.

SIGNATURE_____ DATE: _____