# Reiki Intake Form

Name: _____

Date of birth: _____ Date of initial visit: _____

Phone: _____ Email: _____

Address: _____

City/state/zip: _____

Emergency contact name: _____

Phone: _____ Relationship: _____

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

Have you ever had a Reiki session 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 session(s), 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, your family, or another 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(s) of the 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 medications? Yes _____ No _____

If yes, please list: _____

_____

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?

_____

_____

Would you prefer a hands-on or hands-off Reiki session? (Please circle one.)

Hands-on Hands-off

# 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 this 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 construed 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 that 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 construed 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)*