Twisted Bliss

Reiki Client Information Form

Name: (Please Print) _________________________________ Phone: _______________________

Address: ____

City, State, Zip: ____

Email(optional): ____

Emergency Contact: ____

Current Medications and dosage:

____

Are you currently under the care of a physician? __Yes __No

If yes, physician's name: ____

How did you hear about us? ____

Have you ever had a Reiki session before? __Yes __No

If yes, when was your last session? ____________ Number of previous sessions ______

Do you have a particular area of concern?

____

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____

Are you sensitive to perfumes or fragrances? __________________ Are you sensitive to touch? _______________

I understand that Reiki is a simple, gentle, hands-on energy technique that is used for stress reduction and relaxation. I understand that Reiki practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. I understand that Reiki does not take the place of medical care. It is recommended that I see a licensed physician or licensed health care professional for any physical or psychological ailment I may have. I understand that Reiki can complement any medical or psychological care I may be receiving. I also understand that the body has the ability to heal itself and to do so, complete relaxation is often beneficial. 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.

Signed: _________________________________ Date: _______________

Privacy Notice:No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.