Gabriele

Client Assessment Records

Name: ____

Address: ____

Mobile no : ____

Email: ____

D.O.B : ______________________ Occupation : _____________________

How did you find us? : ____

What are you here for today? ______________________________________

Pregnant ? Yes / No

Are you on medication? If yes, please list:_____________________________

Please circle if you are affected by the following OR If you have had any of the following in the last 12 months. If Yes please provide further information below:

Asthma ~ Sinus ~ Cardiac problems ~ Allergies ~ Car accident ~ Spinal disorder ~ Cancer ~ Depression ~ Anxiety ~ Illness ~ Surgery ~ Migraine ~ Varicose veins ~ Covid or Other:

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<u>Do you have any of the following implants/conditions:</u>

Cardio Stimulator (pacemaker)	yes	no
Deep Brain Implants and other electrical implants:	yes	no
Mental disorders of a severe nature:	yes	no
Cardiac Fibrillation:	yes	no
Metal implants:	yes	no
Organ transplant :	yes	no
Cognitive Implants:	yes	no

I, ____(print name) understand the session provided by GABRIELE is intended to reduce stress, enhance relaxation and increase communication within areas of the body.
I understand that Reiki and Access Bars are not a substitute for medical examination, diagnosis, treatment or medications.
I understand the practitioner does 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/ Access Bars 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/ Access Bars 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
I understand that participation in a session is voluntary and that at all times I may choose to end my participation. In addition, session(s) entail light touching of energy points on the body. Prior to the session, the practitioner will inform me where on the body light touching will occur. If I experience any discomfort during the session, I will immediately communicate that to the practitioner so treatment can be adjusted.
I understand that any information exchanged during the session is educational in nature and is to be used at my own discretion. I also understand that any information imparted during these sessions is confidential and will not be released without my prior written consent, except as required by law.
I understand that by providing this informed consent I am assuming full responsibility for my session and I hold harmless the practitioner, health clinic, and facility/location where the session is provided.
I affirm that I have stated all my known medical conditions, and answered all questions honestly and completely. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I fail to do so.
I give my permission for the use of appropriate equipment (like bolsters, blankets, etc.) to be used in the session as an aid to the practitioner or to ensure my comfort.
Payment by cash or credit is due at the time of service. Since time has been especially reserved for me, I understand that a 24-hour cancellation notice is expected and missed appointments will be charged.
If I have any questions or concerns, I will address these promptly with the practitioner.
I hereby authorise Gabriele to provide me with balancing sessions.

Signature____

Date ____