Reiki Client Intake

Client Consent Form

Client's Information

Full Name: _____ Date: _____

Date of Birth: _____ ☐ Female ☐ Male ☐ NB

Preferred Pronouns: _____

Address: _____ City: _____ ZIP Code: _____

E-mail: _____ Phone: _____

How Did You Hear About Us? _____

Pre-Check In

Please check any treatments you have had before:

- ☐ Reiki or Crystal Reiki
- ☐ Energy Healing
- ☐ Sound Healing
- ☐ Anything Else

Do you have any particular concern or areas you would like to focus on today?

_____

_____

Are you comfortable laying on your back during your session (1 Hr)?

☐ Yes ☐ No

Note: We are able to adjust the session so you will be sitting instead of laying down

Please check what you are **NOT** comfortable with during your session:

- ☐ Crystals
- ☐ Pendulum
- ☐ Singing Bowl
- ☐ Diffusing Oils
- ☐ Candles
- ☐ Sage
- ☐ Palo Santo/ Holy Wood
- ☐ Crystal Bowls
- ☐ Meditation
- ☐ Bells

Are you sensitive to perfumes or scents?

☐ Yes ☐ No

Any conditions that can impact our session?

_____

_____

_____

Anything else you feel is important for your Reiki practitioner to know?

_____

_____