Divine Reiki and Massage

Reiki Client Information Form

Client Name (Please Print) ______________________________________

Date ______________________

Date of birth ______________________

Primary Phone ________________________________ Circle one: cell home

Address ____

City State Zip ____

Email (optional) ____

Referred by ______________________________________

Emergency Contact ____

Are you currently under the care of a physician? □ Yes □ No

If yes, physician's name ____

Current Medications and dosage ____

How did you hear about me? ______________________________________

I consent to receive appointment reminders via email/text □ Yes □ No

Have you ever had a Reiki session before? □ Yes □ No

Do you have a particular area of concern? ____

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Are you sensitive to perfumes or fragrances? _____________________________________

Are you sensitive to touch or prefer no bodily contact? ____________________________

Do you have any allergies? ____