

**CLIENT INTAKE FORM**

**PERSONAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| Last Name | First Name | Middle Initial |
| Date of Birth | Sex | Phone Number |
| Email | Referred By |
| Address |
| City  | State | Zip Code |
| Emergency Contact Name | Phone Number |

**SESSION INFORMATION**

|  |  |
| --- | --- |
| Have you ever had a Reiki session before? YES NO | If YES, when was your last session? |
| # of Previous Reiki Sessions | Results from previous Reiki sessions |
| What benefits are you seeking from your Reiki session? |
| Do you have any particular areas of concern? *(physical, emotional, spiritual)* |
| Are you sensitive to perfumes or fragrances? *(please list type & reaction)* |
| Are you sensitive to touch? *(please explain)* |

**MEDICAL INFORMATION**

|  |
| --- |
| Please list any allergies & reactions *(medication, food, environmental)* |
| Please list any medications and/or vitamins/supplements you are currently taking: |
| Have you had or do you currently have any of the following? *(circle all that apply)*High Blood Pressure Anxiety Stroke/TIAs Indigestion / HeartburnHeart Disease Depression Migraines/Headaches Irritable Bowel SyndromeBipolar Disorder Suicidal Thoughts Difficulty Concentrating Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Schizophrenia Pain *(list location & cause*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please list any other medical conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Healing Practitioner: Jodie Smith

PRIVACY NOTICE:

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