

**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**

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| --- |
| 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 / Heartburn  Heart Disease Depression Migraines/Headaches Irritable Bowel Syndrome  Bipolar 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.*