**Integrative Healing Arts**

Medical and Wellness Massage

**www.iha-holistic.us**

**Brenda Dickenson, LMT, Reiki Master Practitioner**

Reiki Intake Form

**Contact Information Personal Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronoun (optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary phone (home/cell/work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had Reiki before? Yes No

Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, when was your last session?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of previous sessions: \_\_\_\_\_\_\_\_

Any difficulty laying on your stomach or back? \_\_\_\_\_\_\_

Appointment confirmations, appointment reminders, changes to appointments or cancellations and may be sent by email or text message. Please initial here to consent to these messages: **\_\_\_\_\_\_\_**

Are you sensitive to perfumes or fragrances? Yes No

Do you have a particular area of concern? Yes No

If so, please indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to be added to my waiting/notification list? In the event I have a cancellation you may be notified by text message that an appointment time has become available. Initial here to opt in. **\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_

Are you sensitive to touch in any area? Yes No

If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything you would like me to know about

your reiki goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List any current medications or supplements: List any known allergies or hypersensitivities:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please indicate any of the following that apply to you.**

☐ Osteoarthritis ☐ Heart Condition ☐ Anxiety / Depression

☐ Osteoporosis / Bone loss ☐ Stroke ☐ Stress

☐ Back / neck problems ☐ Blood Clots / Clotting issues ☐ PTSD

☐ Broken Bone (in last 2 years) ☐ Deep Vein Thrombosis ☐ Neuropathy

☐ Joint Replacement(s) ☐ High / Low Blood Pressure ☐ Numbness

☐ TMJ ☐ Varicose veins ☐ Carpal Tunnel Syndrome

☐ Headaches / Migraines ☐ Easy Bruising ☐ Epilepsy

☐ Rheumatoid arthritis ☐ Atherosclerosis ☐ Cancer

☐ Fibromyalgia ☐ Circulatory disorder ☐ Diabetes

☐ Autoimmune disorder ☐ Phlebitis ☐ Kidney Dysfunction

☐ Allergies / Sensitivity ☐ Tendonitis ☐ Current Fever

☐ Asthma ☐ Sprains or Strains ☐ Swollen Glands

☐ Recent surgery (in last 2 years) ☐ Recent accident of injury ☐ Open Sores / Wounds

☐ Pregnancy - if so, how far along? \_\_\_\_\_\_\_\_\_\_\_ ☐Contagious Skin Condition

Explain any conditions you have marked above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Release**

**Please take a moment to carefully read the following information and sign where indicated.**

By signing this, I agree that I have answered all questions honestly, to the best of my knowledge and have stated all my known medical conditions. I will inform the practitioner of any changes in my medical condition and/or medications and understand that there shall be no liability on the practitioner's part should I forget to do so. I understand that Reiki is a simple, gentle, hands on energy technique that is used for stress reduction and relaxation. I understand that Reiki Practitioners do not diagnose conditions, nor do they prescribe or perform medical treatments, nor interfere with the treatment of a licensed medical professional. I understand that Reiki does not take the place of medical care. It is recommended that I see a licensed physician or a licensed health care professional for any physical or psychological ailment I may have. I understand that Reiki 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 more than one session in order to facilitate the level of relaxation needed by the body to heal itself.

I understand that any sexual remarks or advances will terminate the session and I will be liable for full payment of the scheduled treatment.

I understand that all payments are due at the time of service.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before the session.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Integrative Healing Arts**

**Brenda Dickenson, LMT**

**COVID-19 ADD**

**CORONA VIRUS/COVID-19 ADDENDUM**

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

CONSENT FOR CARE

To proceed with receiving care, I confirm and understand the following (Initial in all places provided):

* I understand that COVID-19 is extremely contagious and may be contracted from various sources. I further understand that COVID-19 has an incubation period during which carriers of the virus may not show symptoms and still be contagious. \_\_\_\_\_\_\_\_
* I understand that preventative measures, including the wearing of masks, and intensified hygienic and sanitation protocols intended to reduce the potential for spread of COVID-19 have been implemented. However, because the type of work being offered involves close physical proximity over an extended period of time in a closed space, there may be elevated risk. I hereby acknowledge and assume the risk and give my express permission to Brenda Dickenson, LMT to proceed with providing care. \_\_\_\_\_\_\_\_
* I understand that wearing a mask is optional. It is also within my right to ask the therapist to wear a mask during treatment. \_\_\_\_\_\_\_\_

To give your consent, read and sign below:

I knowingly and willing consent to receive massage therapy care from Brenda Dickenson, LMT understanding risks associated with receiving care during the ongoing COVID-19 health crisis. I agree to abide by all rules of the massage provider and her massage practice, as well as shared offices in the building within which it is located, as it pertains to requirements and protocols for COVID-19 both now and in the future.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Integrative Healing Arts**

**Brenda Dickenson, LMT**

**Booking/Cancellation/No show Policy**

**Deposits**

A valid credit card is required to book an appointment. The 50% deposit shall be paid within 3 days of booking an appointment for the appointment to be considered confirmed.

**Cancellation Policy**  
I understand that unanticipated events happen occasionally in everyone’s life.  When you book an appointment that time is reserved especially for you.  Missed appointments are costly in lost time and revenue, and it prevents me from providing services to other clients.  In my desire to be effective and fair to all clients, the following policies are put in place:   
  
**24 hour advance notice is required** when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours advance notice you will be charged 50% of your scheduled appointment charge. This amount will be billed to you and must be paid prior to your next scheduled appointment.   
  
**No-shows**  
Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a no-show and will be charged for their missed appointment. The full amount for the session missed will be billed to you and must be paid prior to your next scheduled appointment.

\*Gift certificates are marked as redeemed for no-shows or cancellation not within 24 hours.

\*No-shows or cancellation not within 24 for hours for packages will be deducted from the package.

\*Gift certificates and packages are non-refundable.

\*All sales, whether online, over the phone or in person are final.

\*Prices are subject to change with or without notice.

**Late Arrivals**  
If you arrive late to your scheduled appointment, your session may be shortened in order to accommodate others whose appointments follow yours.  Your therapist will determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the “full” scheduled session**.

**Payment**  
Full payment is expected before or after treatment at the time of service.  All clients, whether they have received treatment or booked an appointment are bound by this policy without any prejudice or exemption.

**Returned Checks**

There is a fee of $35.00 for a returned check.

By signing this I am stating that I fully understand and agree with the above policy.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_