Integrative Healing Arts

Medical and Wellness Massage

www.iha-holistic.us

Brenda Dickenson, Reiki Master Practitioner

Reiki Intake Form

Name: _____ Date of Birth: _____

Address: _____ City:_____

State:_____ Zip: _____ Phone (home/cell/work):_____

Pronoun: _____ (example: she/her, he/him, they/them) Email Address: _____

Occupation: _____ Referred by: _____

Emergency Contact: _____ Phone: _____

General and Medical Information:

Have you ever had Reiki before? Yes No

If so, when was your last session?_____ Number of previous sessions: _____

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: _____

_____

_____

_____

List any medications or supplements that you are currently taking: _____

_____

_____

Please any known list allergies: _____

Are you sensitive to perfumes or fragrances? Yes No

Do you have a particular area of concern? Yes No If so, please indicate: _____

Are you sensitive to touch in any area? Yes No If so, where? _____

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 compliment 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 if I use a coupon during my visit, it is not valid with any other coupons or promotions. 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: _____

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Medical and Wellness Massage
217 Union Street, Cary, NC 27511
(315) 415-3791

Brenda Dickenson, LMBT
(NY# 28956 NC# 16935)

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.

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 $25.00 for a returned check.

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

Name: _____ Date:_____