Reiki Client Intake Form

Logo Here

General Information

Name | Birthday
Address
City | State | Zip Code
Phone # | Email
Occupation
Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Medical History

Please check all that apply:

☐ Allergy to Nut Oils	☐ Headaches	☐ Pregnant
☐ Arthritis	☐ Heart Attack	☐ Seizure/Epilepsy
☐ Bleeding Conditions	☐ High/Low Blood Pressure	☐ Skin Infections
☐ Blood Clots	☐ Lower Back Pain	☐ Stroke
☐ Bursitis	☐ Low Blood Pressure	☐ Ulcer
☐ Diabetes	☐ Osteoporosis	☐ Varicose Veins

Have you ever been treated for cancer? Yes ☐ No ☐

If yes, when and what types of therapies were used?

Have you had any major injuries? Yes ☐ No ☐

If yes, please explain what and when:

Are you currently taking any medications or under the care of a doctor? Yes ☐ No ☐

If yes, please explain:

Do you suffer from chronic pain? Yes ☐ No ☐

If yes, please explain:

Do you have any allergies and/or sensitivities to fragrances or essential oils? Yes ☐ No ☐

If yes, please explain:

Are you sensitive to touch? Yes ☐ No ☐

If yes, please explain where:

Have you ever received Reiki or Energy Healing? Yes ☐ No ☐ If yes, date: ____________________

Please list your goals, and ares of concern (physical/energetic) for your session here: