Consent Form
Reiki

I, _____ (print name) consent to treatment for myself (or my minor child) _____ (print name), and understand that the services provided by the practitioner **Jonathan Chapman** is intended to enhance relaxation and increase communication within my body.

I understand that these services are not a substitute for medical treatment or medications. I am aware that diagnosis is not given and medication is not prescribed. I agree to continue to have regular medical check-ups as part of my overall health care plan.

I understand that participation is voluntary and that at all times I may choose to end my participation. I understand that I may experience 'healing reactions' during the 24 to 48 hours following the services provided.

I understand that any information exchanged during any session is educational in nature and is to be used at my own discretion. I also understand that any information imparted during these sessions is strictly confidential in nature and will not be shared with anyone without my written permission. I do, however, give the practitioner consent to use my case history and results without using my name. I understand that only the practitioner **Jonathan Chapman** will have access to information in my file to enhance my healing.

I understand that by providing this informed consent I am assuming full responsibility for my services and I hold harmless both the practitioner Jonathan Chapman and the facility/location where the services are provided.

I agree to the terms and conditions set out by this consent form and certify that the above information is true and correct. I agree to pay for distance sessions, should I request them.

_____ _____

Print name Signature

_____

Date

Confidential Client Case History and Intake Form

Name:	Date:
Address:	Phone:
Postal Code:	Email:
Date of Birth:	Referred by:
Would you like to receive updates via email?	

Primary Concerns:	Level: **1**(hardly notice symptoms) to **10** (symptoms are unbearable)

Medications/Remedies/Supplements & Reason for taking:

Significant Accidents/Injuries:

Please place an X beside any conditions that apply (past or present):		
Cancer	Varicose Veins	Allergies:
Heart Disease	H/L Blood Pressure	Surgery:
Diabetes	Paralysis	Genetic Disorders:
Stroke	TMJ Dysfunction	Phobias:
Epilepsy	Arthritis	

Place an X beside any symptoms that you experience:

Headache
Faintness/Dizziness
Tightness in Jaw
Weak body parts
Smoking (#/day__)
Nervousness
Poor Appetite
Excessive Urination
Grinding of Teeth
Heavy feeling in limbs
Blurriness of vision
Constipation
Loose Bowel Movements
Irritated Bowel
Pains in heart/chest
Indigestion
Insomnia
Fatigue
Cold in hands and feet
Lower Back pain
Shoulder/neck pain
Carpel tunnel syndrome
Menstrual Irregularities
Other:

Are you pregnant?

Place an X beside any areas below that you would like improvement in:

Negative self-talk, self-sabotage
Belief in ability to achieve goals
Ability to relax
Ability to use dreams as mental tool for problem solving
Eliminate procrastination
Ability to reach ideal weight
Personal magnetism
Strengthen memory/concentration
Breaking old habits
Release negative events
Ability to align body/mind for self-healing
Ability to take action
Increase learning ability
Beneficial, relationships
Prosperity (attract what you choose)
Attitude and skills at work
Self-Esteem
Youthful Vitality

Below, please describe what you would like to accomplish with these treatments?