



Date: / /

Name: _____ DOB: _____

Address: _____

Phone: H _____ W _____ C _____

Emergency contact: _____ Relationship: _____

Address: _____ Phone: _____

Are you under a doctor's care? Yes No For ? _____

Check ANY that apply to you.

- Joint Replacement / Fusion's
- Pacemaker
- Port
- Lymphedema
- Blood Clots
- Pump
- Medicinal Patches
(i.e. hormonal, morphine, nitroglycerin)
- Other: _____

☯ Are any areas on your body sensitive to touch? _____

☯ Are there any other recent surgeries, conditions or information that you would like for me to know? _____

Initial _____ *Reiki is a complimentary modality and is not a substitution for medical or psychological treatment. It is encouraged that you discuss your session(s) with your health care professional. It is strongly recommended that you inform your Reiki practitioner of any changes in your health care plan(s).*

Initial _____ *I understand that I am receiving Reiki session(s) in a safe and private environment. That I am in control of my care/ session and all information is confidential.*

Initial _____ *I have read a copy of the cancellation policy and I am in full understanding of its parameters.*

Signed _____ Date _____