Client History and Intake Form

I, the undersigned, understand the Usui Reiki Ryoho session given is for the purpose of stress reduction and relaxation. I understand very clearly that this session is not a substitute for medical or psychological diagnoses and/or treatment. Reiki practitioners do not diagnose conditions, nor do they prescribe or perform medical treatments, nor prescribe substances, nor interfere with the treatment of a licensed medical professional. It is recommended that I see a licensed physician or a licensed health care professional for any physical or psychological ailment I may have.

Signature:____ **Date**: __________________

Name: ________________________________

Address: ____________________________________ **Date of Birth** (d/m/y): _______________

____

City/Prov: ____ **Postal Code**: ___________________

Phone (H): ___________________________________ **(Work)**: ____________________________

Email: ____

Occupation: ____

Health History

Are you in good health? Yes ☐ No ☐

How is your blood pressure? Normal ☐ High ☐ Low☐

Are you taking other therapies? Yes ☐ No ☐ *

Are you pregnant? Yes ☐ No ☐

Have you ever had surgeries? Yes ☐ No ☐ *

Have you been pregnant before? Yes ☐ No ☐

Any accidents or serious illness? Yes ☐ No ☐ *

Do you have menstrual/menopausal problems? Yes ☐ No ☐

Are you diabetic? Yes ☐ No ☐

Do you have allergies/sinus conditions? Yes ☐ No ☐ *

Do you have hypoglycemia? Yes ☐ No ☐

Do you have any skin conditions? Yes ☐ No ☐ *

Are you taking medication? Yes ☐ No ☐ *

Do you smoke? Yes ☐ No ☐

Do you sleep well? Yes ☐ No ☐

Do you have a heart condition? Yes ☐ No ☐

Do you have joint problems? Yes ☐ No ☐ *

Do you have headaches? Yes ☐ No ☐

Do you feel stressed? Yes ☐ No ☐

What are you doing for your health? ____

____

When did you last visit your doctor? ____

Have you ever had any situations in the following areas?

Endocrine System	Yes ☐	No ☐	Digestive System	Yes ☐	No ☐
Urinary System	Yes ☐	No ☐	Respiratory System	Yes ☐	No ☐
Cardiovascular System	Yes ☐	No ☐	Nervous System	Yes ☐	No ☐
Immune/Lymphatic System	Yes ☐	No ☐	Reproductive System	Yes ☐	No ☐
Musculo-Skeletal System	Yes ☐	No ☐	Foot problems	Yes ☐	No ☐

Describe:

Do you have:

Pacemaker?	Yes ☐	No ☐	Appendicitis?	Yes ☐	No ☐
Kidney stones?	Yes ☐	No ☐	Unset broken bones?	Yes ☐	No ☐

Do you have difficulty lying on your…?

Front ☐ Side ☐ Back ☐

Is there anything else about your health you would like to tell me? ________________________________

____

____

Have you ever had a Reiki treatment before? Yes ☐ No ☐

How did you hear about Reiki? ____

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Any Yes answers to previous questions with (*) beside them, please elaborate on them here:

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NOTES

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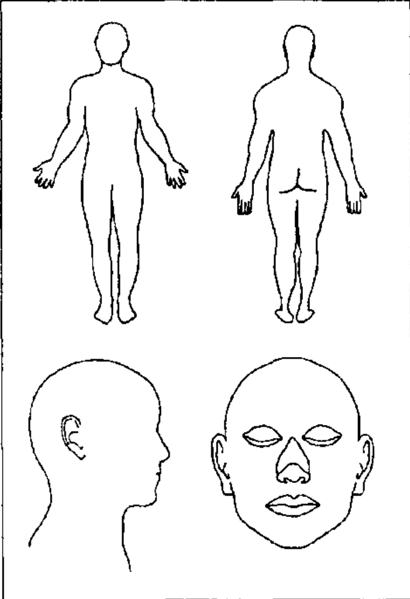
REIKI SESSION RECORD FOR __________________________________

Date: ____________________________

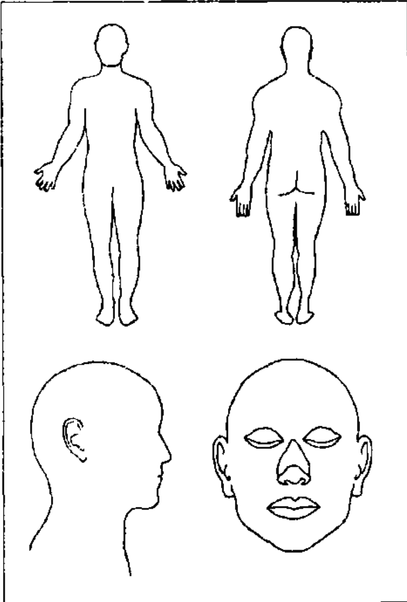


Feedback from last session:

Areas of concern this session:

Post-session notes:

Date: ___________________________



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