Armonía Health LLC Client Intake for Reiki Energy Healing

Name: _____Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Email: _____Can we add you to our email list? YES NO Occupation: _____

Gender: _____ Age: _____ DOB: ____/____/____ Weight: _____ Referred to us by? _____

Name & contact number in case of emergency: _____

Who is your medical doctor? _____ Date of last visit: _____ Reason: _____

Have you received Reiki in the past? _____ Date: _____ Reason: _____

Medications you are currently taking: _____

Supplements/Herbs you are currently taking: _____

Previous accidents, falls and/or surgery, with their dates: _____

_____

Major Complaint

What is your primary reason for this visit? _____

_____

Have you received treatment for this? If so, what? _____ Did it help? _____

CIRCLE any symptoms or illnesses you have currently, **CHECK** any you have had in the past:

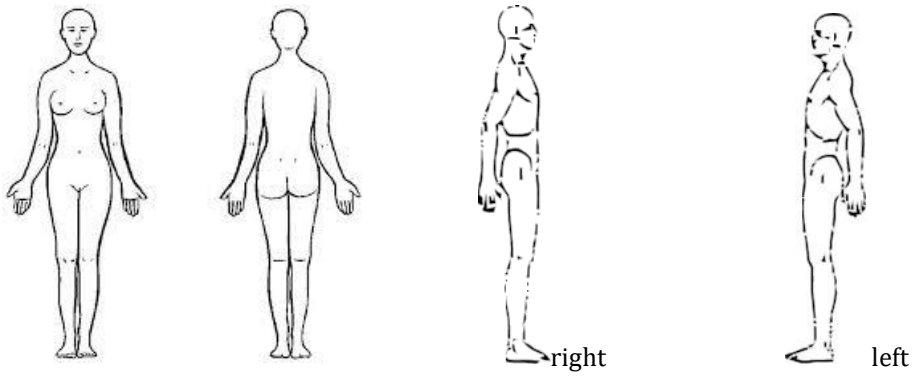
AIDS/HIV	Depression/Anxiety	Hepatitis B/C
Allergies	Diabetes	Indigestion/Acid Reflux
Alcoholism	Ear/Nose/Throat	Insomnia
Arthritis	Epilepsy	Low energy
Asthma	Fertility issues	Poor memory/concentration
Back problems	Menstrual/Hormonal issues	Tuberculosis
Blood pressure (high/low)	Gastrointestinal issues	Vertigo
Cancer	Headache/Migraine	Venereal disease
Cholesterol high	Heart disease	

Smoke? _____ Drink alcohol? _____ Caffeine? _____

List any other conditions or comments you'd like for us to know _____

_____

Circle the areas that currently bother you



Consent Form for Reiki Treatment

1. I understand that Reiki is a Japanese technique of energy channeling based on the placement of hands in order to reduce stress and obtain deep levels of relaxation.

2. I understand that Reiki is considered by the World Health Organization (WHO) as a complementary discipline to any medical, psychological or psychiatric treatment. The Reiki therapist cannot, under any circumstances, modify or suspend any medical or psychological treatment or advise the recipient to do so.

3. I understand that the Reiki therapist cannot make promises of healing my condition.

4. I understand that the Reiki practitioner cannot, under any circumstance make a diagnosis based on the symptoms presented and / or perceived sensations.

5. The Reiki practitioner will keep confidential all customer information. Information will be shared with Armonia Health LLC practitioners if I choose to receive another therapy at this practice.

6. Reiki is delivered while client is fully dressed and lying on a table or seated in a chair.

7. I understand there is a 48 hour cancellation policy, if I do not call to inform the office and leave a message of my cancellation, I will pay 60% of the cost of the Reiki session.

_____ _____

Client Signature Date

_____ _____

Reiki Therapist Signature Date