

## Client History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Occupation/ Activities: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about me? \_\_\_\_\_ May I thank them? \_\_\_\_\_

Have you ever experienced holistic therapies? If so what kinds? \_\_\_\_\_

What professional/ personal goals do you have for yourself? \_\_\_\_\_

Are you currently under a doctors care for a specific problem? \_\_\_\_\_ If so, explain: \_\_\_\_\_

### Health History

**Please update any new health history at each visit.**

Please note and briefly describe any injury, accident, surgery, serious or chronic illness you've had. These might include:

Digestion	__diarrhea __constipation __indigestion __colitis __other: _____
Skin	__allergies __rashes/hives __athletes foot/fungal other: _____
Bones and Joints	__arthritis __break/fractures __bone or joint disease __bone replacements: list locations _____ __Pins/rods placement __Spine/ back, explain: _____
Muscles	__sprain or strain __tendonitis __whiplash __other: _____
Circulation	__high/low blood pressure __varicose veins __blood clots __heart problems, explain: _____ __lymph edema other: _____
Respiration	__asthma __allergies __sinus problems other: _____
Neurological	__headaches __seizures/epilepsy __numbness __sensitive to touch or pressure __sleep disorder __depression __anxiety other: _____
Serious Chronic Condition	__diabetes __tumors/cancer __other chronic disorder, explain: _____
Surgeries	Types/Condition Treated: _____

Please describe any other feeling, symptom or problem regarding your health, fitness or body structure which you feel should be noted or discussed:

\_\_\_\_\_

\_\_\_\_\_

Where is tension most evident in your body? \_\_\_\_\_

\_\_\_\_\_

Do you have any goals for your present state of health? \_\_\_\_\_

**Please initial and sign to verify you have read and understand the terms of your Reiki session**

\_\_I agree to keep the practitioner updated as to any changes in my medical profile and understand that there should be no liability on the practitioners part should I forget to do so.

\_\_I understand that holistic therapies such reiki should not be construed as a substitute for medical examination, diagnosis, or treatment of any medical condition, and that I should see a physician, or other qualified medical specialist or counsellor for any physical or mental ailment I am aware of.

\_\_Holistic Therapies (such as reiki) are provided for the basic purpose of relaxation and relief of muscular tension or stress. Through the relaxation process, holistic therapies may assist to promote balance and normalization of the body naturally.

\_\_I understand that the practitioner does not double book appointments and arranges her schedule to be there. Therefore I understand there is a cancellation policy. I may cancel or change my appointment time up to 24 hours in advance of my session. If I do not show up for my appointment, I will be charged for the full amount.

\_\_I confirm to the best of my knowledge that the answers I have given are correct, and that I have not withheld any information that may be relevant to my session.

\_\_I am aware that my rights to privacy will be maintained. No use of my name will be made without my written consent, in accordance with patient/client confidentiality.

Signature of Client:

\_\_\_\_\_Date: \_\_\_\_\_

Signature of Practitioner:

\_\_\_\_\_Date: \_\_\_\_\_