

Pulling Down the Moon Reiki Intake Form

(Please Print Clearly)

Full Name: _____ Date of Birth: _____

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

Gender: _____ Age: _____ Height _____ Weight: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

How did you hear about us? (doctor, nurse, office staff, flyer, postcard, PDtM website, other website, friend, tv, magazine, internet search) please specify: _____

Primary Care Physician Name and practice location: _____

OB/GYN or Urologist Name and practice location: _____

Reproductive Endocrinologist Name and practice location: _____

In case of a Press Event, would you be willing to share your story? (circle one) YES NO

If YES, please circle which of the following we could contact you about:

Paper/Print Interview Television Radio Testimonial

Are you currently undergoing treatments?(circle one) YES NO

Are you currently using medications? (circle one) Yes NO

If yes, Please provide additional information _____

Have you ever miscarried? (circle one) YES NO

If yes, what date?: _____

Have you had any recent surgeries? (circle one) YES NO

If yes, please provide additional information _____

You may provide an optional synopsis of your fertility history _____

General Information:

Have you ever had a Reiki session before? (circle one) YES NO

If yes, for what purpose? (general wellness, stress, reduction, etc.) _____

What do you hope to accomplish with this Reiki session? (place a check mark to all that apply)

_____ Relaxation _____ Stress Reduction _____ Pain Reduction _____ Other (please explain)

Are you sensitive to fragrances or perfumes?(circle one) YES NO

What is your session preference? (place a check mark next to the preferred method)

_____ Hands-on _____ Hands-off _____ No Preference

Do you have any concerns related to your session or is there anything else we should know?

Client's Signature: _____ Date: _____

Reiki Professional's Signature: _____

Addendum to New Patient Intake
Release of Information Form

I understand that my doctor may be made aware that I am participating in Pulling Down the Moon programming and/or services:

Name

Signature

Date

From time to time, Pulling Down the Moon may find it necessary or helpful to discuss some of the details of your case or treatment with your medical team. By initialing below you authorize Pulling Down the Moon to review your case with your medical doctor and/or nurses.

_____ (Your Initials) I authorize Pulling Down the Moon to correspond or speak with my medical doctor or nurse.

*My Physician's Name/s and practice
(please print) _____*