



Reiki Intake Form

(please print)

First & Last Name Today's Date

Street Address City State Zip

Phone Number Email Address Ht Wt Sex Age Date of Birth

Your Occupation/Employer Emergency Contact (Name & Phone Number)

Primary Care Physician (Name, Practice, Location)

OB/GYN or Urologist (Name, Practice, Location)

Reproductive Endocrinologist (Name, Practice, Location)

How did you hear about us? (doctor, nurse, friend, website, flyer)

In case of a Press Event, would you be willing to share your story? Yes No

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

- Print/Interview TV Radio Testimonial

Health History

What are the health problems for which you are seeking treatment?

How long have you had this condition?

What other forms of treatment have you sought?

Please list any surgeries or major health incidents (year and type)

Are you currently receiving medical treatment for other conditions? Yes No

If Yes, for what conditions?

Are you pregnant? Yes No If Yes, when is your due date?

Please list any current medications

Have you ever had a Reiki session before? 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? 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? _____

Fertility Information

Are you currently undergoing fertility treatment? Yes No

Drug protocol? Yes No

If yes, describe _____

Have you miscarried? Yes No

You may provide an optional synopsis of your fertility history _____

Client's Signature

Date

Practitioner's Signature