Awakening with Diane
REIKI - LIFE COACH - ESSENTIAL OILS

9474 W. Fairview Ave, Boise, ID 83704
awakening.dianeandra@gmail.com
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208-870-2395

Reiki Intake Form

Name: _____

Date of Birth: _____

Date of Initial Visit: _____

Email Address: _____

Address: _____

City / State / Zip: _____/____/_____

Emergency Contact Name: _____

Emergency Contact Phone: ( ) _____

Relationship: _____

The following information will be used to help plan safe and effective Reiki sessions. Please answer the questions to the best of your knowledge.

Have you ever had a Reiki session? ◯ Yes ◯ No

If yes, how often do you receive Reiki? _____

If yes, please describe outcome you hoped for from your previous Reiki session(s), and what your actual experience was:

Do you have any difficulty lying on your front or back? ◯ Yes ◯ No

If yes, please explain:

What is our goal for today's Reiki session? (Please mark all that apply)

◯ Relaxation ◯ General Wellness ◯ Increased Vitality ◯ Stress Reduction

◯ Pain Reduction ◯ Improved Sleep ◯ Other: _____

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Do you experience stress in your work, your family, or another aspect of your life? ◯ Yes ◯ No

If yes, how do you think it has affected your health? (Please mark all that apply)

◯ Muscle Tension ◯ Anxiety ◯ Insomnia ◯ Irritability ◯ Headaches/Migrains

◯ Other: _____

Is there a particular area(s) of the body where you are experiencing tension, stiffness, pain, or other discomfort? ◯ Yes ◯ No

If yes, please explain:

Do you have any allergies or sensitivities? ◯ Yes ◯ No

If yes, please explain:

Are you currently under medical supervision? ◯ Yes ◯ No

If yes, please explain:

Are you currently taking any medications? ◯ Yes ◯ No

If yes, please list:

Is there anything else about your health that you think would be useful for your Reiki practitioner to know to plan a safe and effective Reiki session for you?

Would you prefer a hands-on or hands-off Reiki session? (Please mark one)

◯ Hands-On ◯ Hands-Off

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Reiki Consent Form

I, _____ (print name) understand that the Reiki I receive is provided for the basic purpose of relaxation and relief of tension and stress. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that adjustments can be made for my level of comfort. I further understand that Reiki should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any physical or mental illness, and that nothing said during the session should be construed as such. I affirm that I stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that here shall be no liability on the practitioner's part should I fail to do so.

Signature of Client: _____ Date: _____

Signature of Practitioner: _____ Date: _____

Signature of Parent: _____ Date: _____
(if client is under the age of 18)