

**Intake and Consent Form for Energy Healing at Shift** Date \_\_\_\_\_

Name: \_\_\_\_\_ Age \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Sex: F  M  Preferred contact method (circle): home/cell /email

Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

How did you hear about Reiki at Shift? \_\_\_\_\_

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 before? Yes  No

If yes, how often do you receive Reiki? \_\_\_\_\_

If yes, please briefly describe your purpose for the session and your experience: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is your goal for today's Reiki session? \_\_\_\_\_

List any Allergies or Sensitivities: \_\_\_\_\_

Are you currently under medical supervision? Yes  No  Explain if yes: \_\_\_\_\_

\_\_\_\_\_  
Please list any medications you are currently taking? \_\_\_\_\_

\_\_\_\_\_  
Women Only: Pregnant? Yes  No  If yes, due date: \_\_\_\_\_

Do you have a Seizure Disorder Yes  No

Do you have any Implants (teeth, stents, breast, etc) Yes  No  If Yes: Explain \_\_\_\_\_

Family and home status (single, married, divorced, how many kids, ages, etc): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**\*Please Note** - Late appointments will shorten your session time and session pricing will remain the same.

Are you looking for (check all that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Pain Relief                             | <input type="checkbox"/> Emotional Release          | <input type="checkbox"/> Skeletal Support             |
| <input type="checkbox"/> Stress Relief                           | <input type="checkbox"/> Spiritual Growth           | <input type="checkbox"/> Digestive System Support     |
| <input type="checkbox"/> Relaxation                              | <input type="checkbox"/> Healing Old Wounds/Traumas | <input type="checkbox"/> Urinary Tract Support        |
| <input type="checkbox"/> Addiction Release                       | <input type="checkbox"/> General Wellness           | <input type="checkbox"/> Reproductive Support         |
| <input type="checkbox"/> Healing from Past/Current Relationships | <input type="checkbox"/> Skin Condition Healing     | <input type="checkbox"/> Nervous System Support       |
| <input type="checkbox"/> Increased Energy/Vitality               | <input type="checkbox"/> Muscular Support           | <input type="checkbox"/> Headache/Migraine Relief     |
|  |   | <input type="checkbox"/> Endocrine System Support     |
|  |   | <input type="checkbox"/> Healing of Medical Condition |

Other (explain): \_\_\_\_\_

Explain any above checked box (what issue is and location on the body): \_\_\_\_\_

Please list anything else about your health history that you think would be useful for your Reiki therapist to know to plan effective Reiki sessions for you:

Please list any special health issues or requirements I need to know about (include health restrictions, allergies or other serious health concerns, and if required information on emergency care and your doctor):

7. Integrating other natural therapies/tools may heighten your Reiki session. Please check the box if you're comfortable with me using any of these tools during your session:

- Smudge/Incense       Crystals       Tuning Forks       Essential Oils       Pendulum

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 therapist 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 ailment that I am aware of. I understand that Reiki therapists are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. Reiki is a hands-on holistic health treatment (or hands-off as requested) to encourage relaxation and healing. Reiki is practiced while the client is fully clothed, on a massage table. If at any time you feel discomfort, you may ask for the session to be stopped immediately (session can be resumed after problem is addressed). Sessions are most effective in silence, but sometimes it is necessary to voice what you are feeling, particularly for those unfamiliar with Reiki, in order to feel at ease. Please note, for serious health conditions please see a licensed medical practitioner. For such conditions Reiki is considered a complementary form of treatment. I understand that payment is required at time of services offered.

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent if client is under the age of 18 \_\_\_\_\_

Signature of Reiki Therapist \_\_\_\_\_