CLIENT INTAKE FORM

NAME: PHONE 1:

ADDRESS: PHONE 2:

CITY, STATE, ZIP CODE E-MAIL

EMERGENCY CONTACT NAME: PHONE:

CURRENT MEDICATIONS AND DOSAGE:

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO

PHYSICIAN NAME:

HOW DID YOU HEAR ABOUT ME?

HAVE YOU HAD A REIKI SESSON BEFORE? YES NO

NUMBER OF PREVIOUS SESSIONS

AREAS OF CONCERN?:

ARE YOU SENSITIVE TO FRAGRENCE OF INSCENCE SMOKE: YES NO

ARE YOU SENSITIVE TO TOUCH YES NO

PRIVACY NOTICE:
NO INFORMATION ABOUT ANY CLIENT WILL BE DISCUSSED OR SHARED WITH ANY THIRD PARTY WITHOUT WRITTEN CONSENT OF THE CLIENT OR PARENT/GUARDIAN IF THE CLIENT IS UNDER 18.

REIKI CONSENT FORM

I UNDERSTAND THAT REIKI IS A SIMPLE, GENTLE, HANDS-ON ENERGY TECHNIQUE THAT IS USED FOR STRESS REDUCTION AND RELAXATION. I UNDERSTAND THAT REIKI PRACTITIONERS DO NOT DIAGNOSE CONDITIONS NOR DO THEY PRESCRIBE OR PERFORM MEDICAL TREATMENT, PRESCRIBE SUBSTANCES, NOR INTERFERE WITH THE TREATMENT OF A LICENSED MEDICAL PROFESSIONAL. I UNDERSTAND THAT REIKI DOES NOT TAKE THE PLACE OF MEDICAL CARE. IT IS RECOMMENDED THAT I SEE A LICENSED PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL FOR ANY PHYSICAL OR PSYCHOLOGICAL AILMENT I MAY HAVE. I UNDERSTAND THAT REIKI CAN COMPLEMENT ANY MEDICAL OR PSYCHOLOGICAL CARE I MAY BE RECEIVING. I ALSO UNDERSTAND THAT THE BODY HAS THE ABILITY TO HEAL ITSELF AND TO DO SO, COMPLETE RELAXATION IS OFTEN BENEFICIAL. I ACKNOWLEDGE THAT LONG TERM IMBALANCES IN THE BODY SOMETIMES REQUIRE MULTIPLE SESSIONS IN ORDER TO FACILITATE THE LEVEL OF RELAXATION NEEDED BY THE BODY TO HEAL ITSELF. PARENT/GUARDIAN MUST COMPLETE THIS CONSENT FORM IF CHILD IS UNDER THE AGE OF 18.

PRIVACY NOTICE:
NO INFORMATION ABOUT ANY CLIENT WILL BE DISCUSSED OR SHARED WITH ANY THIRD PARTY WITHOUT WRITTEN CONSENT OF THE CLIENT OR PARENT/GUARDIAN IF THE CLIENT IS UNDER 18.

I AM NOT A MINOR__ (PLEASE CHECK IF OVER 18)

DATE:

.....

CLIENT NAME:

.....

CLIENT SIGNATURE:

.....

SOUND HEALING CONSENT FORM

I UNDERSTAND THAT SOUND HEALING INVOLVES THE USE OF SOUND FREQUENCIES AND VIBRATIONS, PRODUCED BY INSTRUMENTS SUCH AS SINGING BOWLS, TUNING FORKS, GONGS, OR VOICE, TO PROMOTE RELAXATION AND WELL-BEING. I ACKNOWLEDGE THAT SOUND HEALING IS NOT A SUBSTITUTE FOR MEDICAL OR PSYCHOLOGICAL TREATMENT AND IS COMPLEMENTARY TO OTHER HEALING MODALITIES.

I UNDERSTAND THAT:

- SOUND HEALING MAY HELP REDUCE STRESS, IMPROVE RELAXATION, AND ENHANCE A SENSE OF WELL-BEING.
- SOME INDIVIDUALS MAY EXPERIENCE EMOTIONAL RELEASE OR MILD DISCOMFORT AS PART OF THE PROCESS.
- IF I HAVE A PRE-EXISTING MEDICAL CONDITION, SUCH AS EPILEPSY, HEART CONDITIONS, OR SENSITIVITY TO SOUND, I WILL INFORM THE PRACTITIONER BEFORE THE SESSION.

PARTICIPANT RESPONSIBILITY

I CONFIRM THAT:

1. I HAVE DISCLOSED ANY MEDICAL CONDITIONS, INCLUDING PREGNANCY, HEARING SENSITIVITIES, OR MENTAL HEALTH CONCERNS, THAT MIGHT BE AFFECTED BY SOUND HEALING.
2. I WILL COMMUNICATE ANY DISCOMFORT DURING THE SESSION IMMEDIATELY TO THE PRACTITIONER.
3. I AM RESPONSIBLE FOR CONSULTING WITH MY HEALTHCARE PROVIDER ABOUT ANY CONCERNS RELATED TO MY HEALTH BEFORE PARTICIPATING IN SOUND HEALING.

CONFIDENTIALITY AND RELEASE OF LIABILITY

- ALL INFORMATION SHARED DURING THE SESSION WILL BE KEPT CONFIDENTIAL.
- I RELEASE THE PRACTITIONER FROM ANY LIABILITY FOR INJURIES OR ADVERSE EFFECTS THAT MAY ARISE DURING OR AFTER THE SESSION, EXCEPT IN CASES OF GROSS NEGLIGENCE.

PARENT/GUARDIAN MUST COMPLETE THIS CONSENT FORM IF CHILD IS UNDER THE AGE OF 18.

PRIVACY NOTICE:
NO INFORMATION ABOUT ANY CLIENT WILL BE DISCUSSED OR SHARED WITH ANY THIRD PARTY WITHOUT WRITTEN CONSENT OF THE CLIENT OR PARENT/GUARDIAN IF THE CLIENT IS UNDER 18.

AM NOT A MINOR__ (PLEASE CHECK IF OVER 18)

DATE:

.....

CLIENT NAME:

.....

CLIENT SIGNATURE:

.....

REIKI MINOR CONSENT FORM

DATE: .....

CLIENT NAME: .....

PARENT/GUARDIAN NAME: .....

PHONE: .....

I UNDERSTAND THAT REIKI IS A SIMPLE, GENTLE, HANDS-ON ENERGY TECHNIQUE THAT IS USED FOR STRESS REDUCTION AND RELAXATION. I UNDERSTAND THAT REIKI PRACTITIONERS DO NOT DIAGNOSE CONDITIONS NOR DO THEY PRESCRIBE OR PERFORM MEDICAL TREATMENT, PRESCRIBE SUBSTANCES, NOR INTERFERE WITH THE TREATMENT OF A LICENSED MEDICAL PROFESSIONAL. I UNDERSTAND THAT REIKI DOES NOT TAKE THE PLACE OF MEDICAL CARE. IT IS RECOMMENDED THAT I SEE A LICENSED PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL FOR ANY PHYSICAL OR PSYCHOLOGICAL AILMENT I MAY HAVE. I UNDERSTAND THAT REIKI CAN COMPLEMENT ANY MEDICAL OR PSYCHOLOGICAL CARE I MAY BE RECEIVING. I ALSO UNDERSTAND THAT THE BODY HAS THE ABILITY TO HEAL ITSELF AND TO DO SO, COMPLETE RELAXATION IS OFTEN BENEFICIAL. I ACKNOWLEDGE THAT LONG TERM IMBALANCES IN THE BODY SOMETIMES REQUIRE MULTIPLE SESSIONS IN ORDER TO FACILITATE THE LEVEL OF RELAXATION NEEDED BY THE BODY TO HEAL ITSELF. PARENT/GUARDIAN MUST COMPLETE THIS CONSENT FORM IF CHILD IS UNDER THE AGE OF 18.

PRIVACY NOTICE:
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PARENT/GUARDIAN SIGNATURE: .....

DATE: .....