



REIKI INTAKE FORM

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (H) _____ (Cell) _____

Date of Birth: _____ (YYYY/MM/DD) Age: _____ Sex: M / F / _____

Occupation: _____ Email: _____

By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, who should we contact: _____

How did you find out about our services? _____

Patient History:

Have you ever had a Reiki session before? _____ YES _____ NO

Last Session Date: _____

Area(s) of concern: _____

Are you sensitive to fragrance? _____ YES _____ NO

Consent and Liability for Reiki Treatment at Essence Wellness Clinic

Consent: I understand that Reiki involves a natural, holistic, non-invasive hands-on method of energy balancing for the purpose of pain management, stress reduction and relaxation. I understand that any and all information shared between myself and the Reiki practitioner will be treated with the utmost care and confidentiality. I understand very clearly that a Reiki session is not a substitute for medical, or psychological diagnosis, and treatment. I understand that Reiki practitioners do not diagnose conditions, nor do they prescribe, perform medical treatment, nor prescribe substances, nor interfere with the treatment of a licensed medical professional. It is recommended that I see a licensed physician, or licensed health care professional for any physical, or psychological ailment that I may have. By signing below, I consent to the Reiki practitioner placing their hands on or above my body during the session.

Initial: _____

If you DO NOT consent to light touch, please sign here: _____

(turn page →)

Liability: By signing below I agree that I am participating of my own free will. I agree to release, forever discharge and agree to hold harmless my treating Reiki Practitioner(s) and Essence Wellness Clinic from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage or expenses of any nature whatsoever which may be incurred while participating in the Reiki healing session. By signing below, I agree that If I experience any discomfort during the session, I will immediately communicate that to my Reiki practitioner so the treatment can be adjusted.

Initial: _____

Cancellation Policy: I am also aware of the clinic's late cancellation policy of a charge of **50% of the visit cost if I fail to give less than 24 hours notice for cancellations. I will be responsible to pay that charge before I can re-book.**

Initial: _____

Signature: _____ Date: _____