

**Confidential Client Intake Form**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have prior experience receiving professional touch therapy? Y/ N

If yes, please explain and share frequency? \_\_\_\_\_

What is your Primary Reason/Goal/Focus for today's appointment? \_\_\_\_\_

Are you open to receiving Reiki (energy work) as a part of today's session? Y/N

Are you currently receiving treatment from a physician or another health care provider? Y/N

If yes, please explain: \_\_\_\_\_

Have you experienced a significant life change recently or at present? Y/N If yes, please explain:

Do you have any issues you would like to bring to my attention regarding your present experience? Y/N

Please circle that which applies to your current experience and/or past:

Surgery Accidents Injury Hospitalization Inflammation Cancer HIV/AIDS

Varicose Veins Skin Rash/Cut/Bruise Cold/Flu Allergies Pregnancy (term \_\_\_\_\_ )

Spinal/Joint issues Arthritis Chronic Pain Back/Neck/Shoulder pain Diabetes

Medications/Herbs/supplements PMS Blood Pressure High/Low Headaches

Please expand upon that which has been circled and list other conditions, issues and medications not listed above: \_\_\_\_\_

I, \_\_\_\_\_ understand that treatment given here is for the purpose of promoting relaxation, increased energy flow, clarity, self awareness, and health building balanced energy. I understand that Massage Therapists do not diagnose illness, disease or any physical or mental disorders. I understand that Massage Therapists do not prescribe medical treatment or perform spinal manipulation. I take responsibility for informing my practitioner of any physical, mental or emotional changes that occur with my health.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_