



PATIENT/CLIENT INTAKE FORM

The following information needs to be gathered in order for us to formulate a safe and effective treatment plan for you. This information will be kept confidential and cannot be released without your written consent unless obliged by law. This information may be shared amongst other health information custodians or circle of care for the purpose of your health care. Please feel free to ask any questions about the information being requested.

Full Name					
Date of Birth (MM/DD/YYYY):		Gender: Male or Female			
Cell Phone:	Home Phone:	Work Phone:			
Email Address:					
Address:		Apt #:			
City:	Province:	Postal Code:			
Occupation:					
Who may we thank for referring you to our care?					
General Health Background:					
Physician Name:					
Allergies:					
Do you participate in any sports or activities?					
Are you currently on any medications?					
General Health History:					
Are you currently being treated for any of the following:					
Heart Conditions		High/Low Blood Pressure		Fainting or Dizziness	
Varicose Veins		Circulation Problems		Headaches or Migraines	
Neck Injury		Back Injury		Jaw or Ear Pain	
Osteoporosis		Rheumatoid Arthritis		Osteoarthritis	
Cancer		Kidney Disease		Skin Conditions	
Crohn's Disease		Pelvic Inflammatory Disease		Epilepsy	
Nervous Disorders		Whiplash		Other:	
Have you received care from any of the following: (circle)					
Physiotherapist	Chiropractor	Massage Therapist	Naturopath		
Other:					
What is the reason for this treatment?					
Have you had surgery in the past? If yes, for what?					
Have you had any fractures or sprains in the past? If yes, where?					
Have you had any serious illnesses in the past? If yes, what?					

Treatment Related Questions:	
Sometimes, during a Reiki session the practitioner/therapist will place their hands upon you. Are you OK with being touched "appropriately" during the Reiki session or do you prefer to not be touched at all?	
_____ Touch is okay _____ Prefer not to be touched	
**Inappropriate touch of any kind by the Reiki practitioner or the client is a breach of the Reiki Code of Ethics	
What is your main reason for the Reiki session today?	
Relaxation and Stress Reduction	Specific Issue
If Reiki is targeting a specific issue, how would you describe it:	
Physical:	
Emotional:	
Mental:	
Spiritual:	

Informed Consent for Reiki Treatment:

I hereby consent for my Reiki therapist to treat me with Reiki therapy including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that Reiki therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the Reiki therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my condition for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

All information is solely collected for the internal use of InsideOut Wellness Centre and will not be shared with any third parties. InsideOut Wellness Centre is the guardian of my file. My file will only be released with a duly executed authorization form signed by me.

I understand, have read and completed this questionnaire truthfully to the best of my ability. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I consent to the service being undertaken and I hereby indemnify InsideOut Wellness Centre and its Owners & Staff from any claims whatsoever. I understand that there are no guarantees or refunds as to the results of this service. I hereby agree to all of the above and grant my permission to have this treatment performed on me.

Client Name (Printed): _____

Client Signature: _____ Date: _____