Lakeside Natural Health
CENTRE

Reiki Intake Form

Today's Date: _____
Name:_____ Age: _____Birth date: _____ M ☐ F ☐
Address: _____City: _____Postal: _____
Home Phone #: _____ Work Phone #:_____
E-mail: _____ Other Contact (parent/spouse)? _____
Occupation: _____ Referred by?: _____
Chief concerns – mental, physical or spiritual:

Medical & Lifestyle Information

Are you currently being treated at this time? If yes, describe treatment plan & practitioner(s):

Please list any serious past or present illnesses or diseases (e.g. cancer, asthma, reflux, etc.)

Please list any medications you presently use, and their purpose:

Reiki Related

What are your goals in receiving reiki treatments?

Have you ever had reiki or energy work before? If yes, describe:

Any experience with:

☐ Yoga	☐ Biofeedback	☐ Tai Chi
☐ Meditation	☐ Shiatsu	☐ Other

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being, and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Signature:_____ Date: _____
Name (printed):_____