REIKI
FOR PEOPLE AND ANIMALS

Health History and Treatment Consent Form (People)

Client's name_____

Parent/guardian's name (if under 18): _____

Email _____

Phone_____

Address_____

_____

Emergency contact number _____

Do you drink alcohol Yes_____ No_____

Do you use recreational drugs Yes_____ No_____

Medical health conditions/concerns Please list _____

_____

General/current state of health _____

Any longstanding/chronic conditions _____

_____

Childhood and adult illnesses _____

Current medications/herbs _____

Allergies and/or allergies to medications _____

Are you currently seeing a doctor or health practitioner for treatment Yes____ No____

Vaccinations _____

Have you suffered any significant traumas or accidents _____

_____

Have you ever had a Reiki session. Yes____ No____

Do you have a particular area of concern/reason for session _____

_____

How did you hear about us? Friend ____ Internet search ____ social media ____ Other ____

- I understand that Reiki is not a substitute for medical attention, examination, diagnosis, or treatment.
- I understand that at all times my personal body privacy will be maintained. I am not required to remove any clothing except my shoes.
- I confirm that I have no medical condition or other limitations that should prevent me having a Reiki treatment.
- **I have been advised that if I suspect I may have a medical condition I should seek help from a qualified medical practitioner.**
- I confirm that the details given by me to the Practitioner are correct and that if any of the personal information given changes, then I accept I must inform the Practitioner accordingly.
- I understand that all information will be treated in strictest confidence.
- The Practitioner has fully explained the treatment and the procedures involved.
- I have had the opportunity to ask questions about the above and I am willing to proceed with the treatment.
- I am over 16 years of age. The above information is true to the best of my knowledge, and I have not withheld any relevant information. I understand that I am financially responsible for all payments and consent to the treatment.

Client Name_____

Client signature _____

Date _____

No treatment can take place without a fully completed consent form. Please sign and return it before the session. Alternatively, there is a PDF version available for download here. Thank you.

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