



RESTORE • REJUVENATE • RESET

Client Information Form



Please complete this form and bring it with you to your first appointment.

Personal Details

Full Name: _____

Date of Birth: _____ Date of Appointment: _____

Address: _____

Email Address: _____

Contact Telephone Number: _____

Emergency Contact

Name: _____

Relationship: _____

Contact Number: _____

Medical Information

Please provide details of any current medical conditions or medications that may need to be considered prior to your treatment.

All information will be treated in the strictest confidence.

Health Screening

Please tick or circle as appropriate:

- | | |
|--|----------|
| • Do you have a pacemaker or any heart condition? | Yes / No |
| • Are you, or could you be, pregnant? | Yes / No |
| • Are you currently recovering from surgery? | Yes / No |
| • Do you have diabetes? | Yes / No |
| <i>If yes, please specify type: _____</i> | |
| • Are you able to climb stairs? <i>(The treatment room is located upstairs. Alternative arrangements can be made if required.)</i> | Yes / No |

Treatment Preferences

Reiki can sometimes include intuitive or spiritual elements. Please indicate your preference:

- ☐ I am comfortable with intuitive or spiritual elements if they arise naturally
☐ I prefer a non-spiritual, relaxation-focused treatment
☐ I am unsure and would like to discuss this before we begin

Consent

I understand that Reiki is a complementary therapy and not a substitute for medical treatment or diagnosis. I confirm that the information provided above is accurate to the best of my knowledge, and I consent to receive Reiki treatment.

Signature: _____

Print Name: _____

Date: _____

