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**CLIENT INTAKE FORM**

Please fill out and bring this intake form to your appointment. We'll go over it with you before treatment begins.

Name \_\_\_\_\_ ID # \_\_\_\_\_

Address \_\_\_\_\_ Date \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Age/DOB \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by? \_\_\_\_\_

Reason for Coming? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Who do you live with? Please include all people, pets, etc. \_\_\_\_\_

\_\_\_\_\_

Do you have any medical conditions? \_\_\_\_\_ If yes, please list those conditions below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you now under a doctor's care? \_\_\_\_\_



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Are you taking any meds/vitamins? \_\_\_\_\_ If yes, please list those conditions below.

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Any significant past medical history? \_\_\_\_\_ If yes, please explain. \_\_\_\_\_

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Please explain the following factors of your life.

Personal Stress?

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Work Stress?

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Sleeping Habits?

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Exercise/Self-care?

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Meditation Experience?

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What do you hope to accomplish with this treatment?

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What are your long and short-term goals for the quality of your life?

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