

Grace Labyrinth, LLC

Long Distance Reiki Client Intake Form

First Name _____ Last Name _____

Phone _____ Email _____

Address _____ City, State, Zip _____

Date of Birth _____

Emergency Contact _____

Emergency Contact Phone Number _____

How did you hear about Grace Labyrinth Wellness Center?

___ Family/friend/colleague ___ Web search ___ Healthcare Professional Other _____

If referred, by whom? _____

Are you currently under the care of a physician for any medical conditions? Yes ___ No ___

If yes, physician's name and phone number _____

If yes, please describe your medical condition(s) and any relevant medication(s).

Have you ever had a Reiki session before? Yes ___ No ___

If yes, for what purpose? (general wellness, stress reduction, etc.) _____

Do you prefer hands-on Reiki or hands-off Reiki for your session?

___ Hands-on Reiki ___ Hands-off Reiki

If you prefer hands-on Reiki, please list any areas of the body you wish to be avoided.

Are you sensitive to any essential oils and/or fragrances? Yes ___ No ___

If yes, please list essential oils and/or fragrances you are sensitive to. _____

If you feel comfortable, please share your spiritual and/or religious affiliation (God, Universe, Mother Earth, Spirit Guides, Angels, etc.).

Please sign below to certify that the information you provided above is true and accurate, and that you have honestly detailed all your known medical information.

Client Signature

Date