

Client Consultation Form

The following information is required for your safety & to benefit your health.

All information will be treated in the strictest of confidence & will not be discussed or passed onto a third party.

Name: _____	Telephone Number: _____
Address: _____	Mobile No. _____
_____ Post Code _____	Date of Birth: _____
Occupation: _____	Age _____

Emergency Telephone No.	<u>Three Objectives you would like to achieve</u> 1) _____ _____ _____ _____ _____ 2) _____ _____ _____ _____ _____ 3) _____ _____ _____ _____ _____
Name of Doctor:	
Telephone Number	
Have you had Reiki before? Yes / No	
<u>Are you taking any regular medication?</u> Yes / No	
<u>Details of Medication</u> _____ _____	
<u>Is your General Health</u> good / average / poor?	
<u>Are your Stress Levels</u> high / average / low?	
<u>Is your Sleeping Pattern</u> good / average / poor?	
<u>Are your Concentration Levels</u> good / average / poor?	
<u>Are your Energy Levels</u> high / average / low?	
<u>Do you get time for Hobbies / Relaxation?</u> Yes / No	
<u>Emotional state?</u>	

Client declaration

I declare that the information I have given is correct and as far as I am aware I can undertake treatments without any adverse effect. I have been fully informed about any of the treatments contra-indications and contra-actions and I am therefore willing to proceed with treatment. I understand that the therapist holds no responsibility for any adverse reactions to this treatment or any subsequential treatments undertaken. I also understand that I am responsible for my own health, safety and well being.

To Be Filled in by Client –

If GP referral was necessary, has your GP given consent for treatment Yes / No?

Client Signature

Date: