Appointment/Intake Form

(All written or sessional information will be confidentially maintained.)

Date: _____ Name: _____

I am interested in _____ session(s).

Date of Birth: _____ Email: _____

Home number: _____

Work number: _____

Cell number: _____

Address: _____

Street City/Province Postal Code

Language(s): _____

Emergency Contact Person: _____

Name Phone City

Medical Condition(s) (circle):

Thyroid Disease	☐	Food Sensitivities	☐	Allergies	☐
Hypoglycemia	☐	Mitral Valve Prolapse	☐	Depression	☐
Anemia	☐	Inner Ear Problem	☐	Anxiety Disorders	☐

Vitamin Deficiency _____

Heart Disease _____

Other(s) (please list) _____

Purpose of session:

Do you have an established support system? Who?

Please share a future dream or goal that you have:

1. My favourite colour is: _____.

2. I sometimes/chronically have pains/cramps/aches in the following places:

3. I feel the following emotions quite a lot or chronically:

4. I cannot feel the following emotions or body parts often/well:

_____

_____

_____

_____

5. My best time of day is: _____

6. My worst time of day is: _____

Please answer the following questions:		
	Yes	No
I have experienced a Reiki session before.		
I have had a Chakra Balancing session before.		
I have had an Integrated Energy Therapy before.		
I know about chakras.		
I have used holistic remedies for my growth and development.		
I have a spiritual path that I am consciously following.		
I have experienced trauma.		
I have difficulty adjusting to new situations and/or people.		
I am generally uncomfortable with touch.		
I am generally uncomfortable expressing myself.		
I love myself.		
I accept myself.		
I am comfortable asserting myself.		
I feel like I belong.		
I feel connected to the world around me.		

Is there anything else you wish to share?

_____

_____

_____

_____