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## Client Information Form

I understand that Massage/Reiki-Energy Work is a stress reduction and relaxation technique. I acknowledge that treatments administered are only for the purposes of helping me relax, to relieve stress and promote healing. Massage/Reiki-Energy Work practitioners do not diagnose conditions, nor do they prescribe substances or perform medical treatment, nor interfere with the treatment of a licensed medical professional. It is recommended that I see a licensed physician, or licensed health care professional for any physical or psychological ailment I may have. I understand that Massage/Reiki-Energy Work can complement any medical or psychological care I may be receiving.

I also understand and believe that the body has the ability to heal itself, and to do so complete relaxation is often beneficial. Long term imbalances in the body sometimes require multiple treatments to allow the body to reach the level of relaxation necessary to bring the system back into balance. I understand and believe that self-improvement requires commitment on my part, and that I must be willing to change in a positive way if I am to receive the full benefit of a Massage/Reiki-Energy Work treatment.

I acknowledge my commitment to my self-improvement process. I recognize that a Massage/Reiki-Energy Work treatment program must be followed to be truly effective, just as prescribed medication is only effective if taken as directed.

I understand that if I need to cancel a scheduled appointment, I will provide 48 hour notification. If an appointment is cancelled or rescheduled in less than 24 hours, I am responsible for a fee of 50% of the fee for service.

Print Name_____ Signed_____

Client's Representative_____ Signed_____

Date_____ DOB _____

Address_____
(Include city and zip)

Phone_____ Cell Phone_____

Email_____ would you like to be on my email list Yes_____ No _____

Have you ever had a Massage/Reiki-Energy Work session before? __Yes __No
If yes, when was your last session? _____
Number of previous sessions _____
Do you have a particular area of concern? _____
_____
_____
Are you sensitive to perfumes or fragrances? _____
Are you sensitive to touch? _____

List treatments or medications client is currently receiving?

| Medication or Treatment Type | Dosage or Frequency | When did they start |
|---|---|---|
| | | |
| | | |
| | | |

Comments and history _____
_____
_____

Privacy Notice:
No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.

Do you use tobacco?
current former never

Are you exposed to tobacco smoke at home, work or elsewhere? Yes No