

NEW PATIENT INTAKE FORM – REIKI

Appointment Date: _____

Please complete the following pages so we can best meet your healthcare needs. If you have any questions, please do not hesitate to ask.

Personal Information

Name:

(First) (Middle) (Last)

Date of Birth: _____
(DD/MM/YYYY)

Occupation: _____ **Relationship Status:** _____

Address: _____

City: _____ **Province:** _____ **Postal code:** _____

Phone numbers: _____
(Home) (Cell) (Other)

(Work) (Ext)

Main Email:

(Used for appointment reminders and other information, if any)

Emergency Contact Details:

Name: _____ **Relationship:** _____

Phone Number: _____

Physician Name: _____ **Physician Number:** _____

How were you referred to us?

Have you received Reiki or energy work before? Y / N

If yes, when was your last session?

What other treatments are you currently receiving? (Acupuncture, Nutritionist, Doctor, Massage etc.)

What would you like to focus on during your session today? Mind/Emotions, Body, and/or Spirit/Soul

1) _____

2) _____

3) _____

Is there anything you would like to share/discuss that may influence your session

Are you sensitive to essential oils? Y / N _____

Are you sensitive to touch or sound? Y / N _____

Are you currently taking any medications? Y / N _____

CONSENT FOR TREATMENT

I, _____, hereby consent for my therapist to treat me with reiki, sound therapy, ozone, guasha or cupping for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that the above therapies are not a substitute for a medical examination. It is recommended that I see my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of any existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I understand that Intuitive Readings are different than Reiki and can be included as part of my session or refused upon request. I understand I must be over 18 to receive a Reading, or have permission from my legal guardian. I understand how I choose to use, or not use, the notes provided from an Intuitive Reading is 100% my own responsibility. I understand the Reiki practitioner is not able to give financial, legal or medical advice.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____ (Patient/Guardian Signature)

Signed this _____ day of _____, 20_____

Fort Saskatchewan Acupuncture
#301, 10101 86 Ave
Fort Saskatchewan, AB, T8L 0T6
(587) 285-8012
www.fortsaskacupuncture.com

PAYMENT AND APPOINTMENT POLICIES

Patients are responsible for all payments for treatments and supplements. For your convenience, direct billing for insurance coverage is provided. However, the patient is responsible for payment of all outstanding dues not covered by the insurance provider.

For your convenience, appointments may be booked online or by telephone. Cancellations of at least 24 hours prior to appointment time may also be done via our online booking system or by telephone. However, appointment cancellations without 24-hour notice will be charged a \$45 cancellation fee.

I, _____, understand and agree to the payment and appointment policies of Fort Saskatchewan Acupuncture Ltd.

_____ (Patient/Guardian Signature)

Signed this ____ day of _____, 20____

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