

Client Intake Form
+Many Rivers II Wellness +
+ Reiki + Integrative Holistic Indigenous Healing +
+ Aromatherapy + Essential Oils + Crystal Therapy+
Lorri Many Rivers Santamaría, PhD, RYT200, Reiki Master

Personal Information

Name _____ email _____

Phone (Cell) _____ Phone (Home) _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective Reiki/ Integrative/ Holistic healing sessions.

Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional Reiki/ Integrative/ Holistic healing before? Yes No
If yes, how often do you receive Reiki/ Integrative/ Holistic healing therapy?

2. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain

3. Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses dentures a hearing aid ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe

8. Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?
Muscle tension anxiety insomnia irritability other

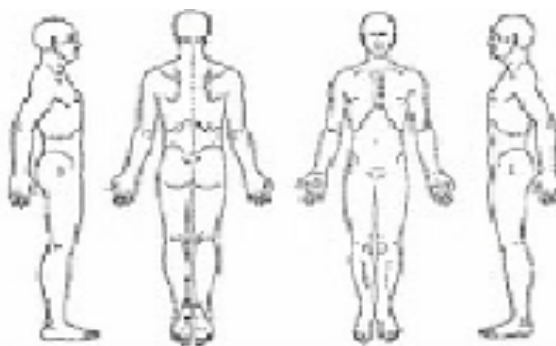
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please identify

10. Do you have any particular goals in mind for this Reiki/ Integrative/ Holistic healing session? Yes

No

If yes, please explain



Circle any specific areas you would like the massage therapist to concentrate on during the session

Medical History

In order to plan a Reiki/ Integrative/ Holistic healing session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No

If yes, please explain

12. Do you see a chiropractor? Yes No If yes, how often?

13. Are you currently taking any medication? Yes No

If yes, please list

14. Please check any condition listed below that applies to you:

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident of injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> cancer |
| <input type="checkbox"/> current fever | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> atherosclerosis | <input type="checkbox"/> pregnancy if yes, how many months? |

Please explain any condition that you have marked above

15. Is there anything else about your health history that you think would be useful for your Reiki/ Integrative/ Holistic healing practitioner to know to plan a safe and effective massage session for you?

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