HOLISTIC WELLNESS
OTTAWA

Reiki, Chakra Balancing and Energy Healing Intake

Thank you for taking the time to fill out the requested information. Confidential when completed.

PERSONAL INFORMATION **Date: _____**

Name: _____ Date of Birth(dd/mm/yy): _____

Why are you here today? _____

_____

What do you hope to achieve from this treatment or therapy? _____

_____

Have you had energy healing before, if so what type? _____

_____

Do you wish to share with me any emotional or physical traumas you have experienced: _____

_____

Please list any specific health concerns. _____

_____

Are you currently under the care of another health care provider? If so who and for what? _____

_____

_____

Current medications: _____

_____

Anything else I should know? _____

_____

_____

_____

Disclaimer and consent to receiving treatment

I understand that Reiki, Chakra Balancing and Energy Healing are gentle, hands-on (or, if required, hands off) energy techniques.

I understand that Reiki, Chakra Balancing and Energy Healing practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional.

I understand that Reiki, Chakra Balancing and Energy Healing do not take the place of medical care. 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 Reiki, Chakra Balancing and Energy Healing can complement any medical or psychological care I may be receiving.

I acknowledge that it may sometimes require more than one session in order to facilitate the body's ability to heal itself.

Reiki, Chakra Balancing and Energy Healing are a holistic health treatment to encourage relaxation and facilitate healing.

Reiki, Chakra Balancing and Energy Healing are practiced while the client is fully clothed, on a massage table.

If at any time I feel discomfort, I will inform the practitioner immediately and can stop the session at any time.

I understand that during the session I can remain silent, ask questions or share what I am experiencing with the practitioner and that I may move if needed.

I confirm that I have read and understand the above.

I give permission to Sue Taylor / Debra Ramsay (circle one) to perform such services as outlined above, and state that I have disclosed any information (health or otherwise) that may alter the effectiveness of services offered.

Signed: _____ Date: _____

Privacy Notice: No information about any client will be discussed or shared with any third party without your explicit consent.

Phone: 613 230 0998 www.ottawaholisticwellness.ca