Client Documentation Form

Date: _______________

Name: ______________________________ Email Address: __________________________________

Address: ____ Phone: _______________________

City, State, Zip: ____

List all medications:

____

____

Are you currently under the care of a physician? ___Yes ___ No
If yes, physician's name:____

Have you ever had a Reiki, Bars or Polarity session or energy work before? ___Yes ___ No
If yes, when was your last session and what was the modality used?
____ Number of previous sessions _________

List all past surgeries/broken bones/accidents:

____

____

List all current and past medical diagnoses (cancer, diabetes, etc,) :

____

____

List your current health concerns:

____

____

What do you want to work on today?

____

____

Are you sensitive to essential oil fragrances?________________________

Are you sensitive to touch? ________________________

Name____

I understand that Reiki, Bars, Polarity Therapy and energy work are simple, gentle, hands-on energy techniques that are used for stress reduction and relaxation. I understand practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of licensed medical professional. I understand the energy work does 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 the energy work can complement any medical or psychological care I may be receiving. I also understand that the body has the ability to heal itself and to do so, complete relaxation is often beneficial. I acknowledge that long term imbalances in the body sometimes require multiple sessions in order to facilitate the level of relaxation needed by the body to heal itself.

Signed: ____ Date:________________________

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 of the client is under 18.

Name____Date___________________________________

Check all items listed below the re-appear in your life. (**D**=Daily **M**=once a Month **Y**=twice a Year)

Ether Element

________Any ear difficulty
________Any thyroid difficulty
________Internal tension
________Painful joints
________Insomnia
________Any throat difficulty
________Lack of spiritual awareness
________Tightness in the throat
________Nervousness
________Burnout
________No free time
________Irritability
________Any change in speech
________Self-pity
________Communication difficulty
________Sinus difficulty

Air Element

________Asthma
________Headaches
________Shortness of breath
________Smoking history
________Pneumonia
________Loss of memory
________Fainting
________Tightness in the shoulders
________Heart difficulties
________Grief for recent death
________Allergies
________Epilepsy, seizures

Fire Element

________Indigestion
________Liver difficulties
________High Blood pressure
________Cold hands
________Eye difficulties
________Any problem with anger
________Ulcers
________Diabetes
________Stomach disorders
________Cold feet
________Lack of concentration
________Alcoholism

Water Element

________Psoriasis
________Anemia
________Low blood pressure
________Any kidney difficulty
________Cold feet
________Depression
________Any urination difficulties
________Any difficulty with your cycle
________Loss of taste
________Swollen ankles
________Reproductive disorder
________Bladder difficulties
________Over emotional
________Any female difficulties
________Burning or pain during sex
________Prostate difficulties

Earth Element

________Constipation
________Too much gas
________Neck aches
________Colon problems
________Feeling lethargic
________Being attached to emotions
________Diarrhea
________Overweight
________Lack of balance
________Not being flexible
________Feeling resentful
________Being attached to things