



REIKI SESSION FORM & WAIVER

DATE: _____

Name: _____ **Phone:** _____

Address: _____ **City, State, Zip:** _____

Email: _____

Emergency Contact: _____ **Phone:** _____

Current Medications and Dosage: _____

Are you currently under the care of a physician? __ Yes __ No

If yes, physician's name: _____

How did you hear about us? _____

Have you ever had a Reiki 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 touch? __ Yes __ No

I understand that Reiki is a simple, gentle, hands-on energy technique that is used for stress reduction and relaxation. I understand that Reiki 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 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 that Reiki 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.

Signature: _____ **Date:** _____



Reiki Documentation Form

Client Name: _____ Date: _____

Reason for Session:

Relaxation and Stress Reduction

Specific Issue:

Physical

Emotional

Mental/Spiritual

Changes since last session

Observation / Scan before Reiki Session:

Observation / Scan after Reiki Session: _____

Post Session Notes: _____

Length / Type of Session: _____

Follow up Planned: _____
