Dorothy Hughes, MS, NCC, LMHC
Licensed Mental Health Counselor (IN License 39000908A)
Level III Reiki Practitioner
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REIKI CLIENT INFORMATION SHEET

Name: _____ D.O.B. _____ Phone: _____
Address: _____ City: _____ State: __ Zip: _____
Email Address: _____ Referred by: _____
In case of emergency contact: _____
I have received Reiki treatment in the past: __ yes, when _____; __ no

Please check off each statement indicating you understand and agree with the statement.

____ I understand that keeping the body in a balanced state of health requires all its systems to function optimally.
____ I understand that a Reiki treatment assists the functioning of the body by simply inducing relaxation.
____ Reiki practitioners do not diagnose, prescribe, or otherwise indicate a claim that healing will take place as a result of this or subsequent sessions.
____ Licensed health professionals should be sought out for any care beyond the scope of this treatment.
____ In light of my awareness, I recognize that a series of treatments or a Reiki program may best service me on my path to healing.
____ The results, like any program, are cumulative.

_____ _____
Client Signature Date Witness Signature Date

Rate the current level of the distress, 10 the highest stress or pain, 0 the least.

Symptom/condition	Duration	Discomfort Scale 0 (none) – 10 (high)
Anxiety		
Depression		
Headaches		
Sleep Difficulties		
Tension/soreness		
Migraines		
Stomach Problems		
Joint Pains		

If your discomfort or condition is other than listed above, please describe:

_____
_____
_____
_____
_____