BURNS INTEGRATIVE WELLNESS CENTER

Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

Office: 623-252-0376
Fax: 623-399-1059

Reiki Client Intake Form

Personal Information

Name _____ Age _____ Date of Birth _____
Height _____ Weight _____ Gender ☐ Male ☐ Female

Address _____
City _____ State _____ Zip _____

☐ Married
☐ Divorced
☐ Single
☐ Widow
Children _____

Home Phone _____
Cell Phone _____
Work Phone _____
Email Address _____

Spouse _____ Phone _____
Emergency Contact _____ Phone _____

Occupation _____ ☐ FT ☐ PT
Employer _____

Primary Care Physician _____ Phone _____
☐ Y ☐ N Is it okay if we contact them about your care?

☐ Y ☐ N Would you like to subscribe to out newsletter? [No more than 1-2 emails per month] Our newsletter includes health-related articles and healthy recipes.

☐ Y ☐ N Is it okay if we send SMS text appointment reminders to your mobile phone?

How Did You Learn About Our Office?

☐ Attorney ☐ Family ☐ Google ☐ Other _____
☐ Mailer ☐ Co-Worker ☐ Yelp ☐ Counselor / Therapist
☐ Friend ☐ Physician ☐ Facebook ☐ Instagram

If referred, by whom _____

Signature Patient | Patient Name [Printed] | Date

If needed, Signature of authroized representative | Representative Name [Printed] | Relationship to patient | Date

Authorized Facility Signature | Date

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Reiki Questionnaire

☐ Y ☐ N Have you ever had a Reiki session before? If YES, when was you last session? _____

Number of previous sessions: _____

Do you have a particular concern?_____

_____

_____

_____

_____

_____

_____

_____

Privacy Notice

No information about any client will be discussed or shared with any third party without written consent of the client or the parent/guardian if the client is under 18.

Consent

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 so 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.

Cancellation Policy

To better serve our patients, we require 24-hour notice if an appointment is to be canceled or rescheduled. This will ensure maximum availability to all patients who need to see us.

If you do not provide us 24 hours advance notice of cancellation you will be responsible for the entire payment of the office visit.

Signature Patient	Patient Name [Printed]		Date
If needed, Signature of authroized representative	Representative Name [Printed]	Relationship to patient	Date
Authorized Facility Signature			Date