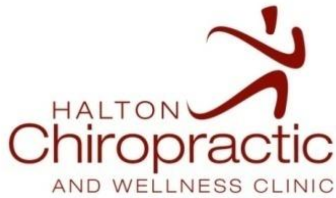

250 Wyecroft Road, Suite #5
Oakville, ON L6K 3T7
Tel: (905) 844-9117
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REIKI

NEW PATIENT QUESTIONNAIRE

Name: ____ Date: ____________________
(Last) (First)

Address: ____
(Street) (City)

____
(Province) (Postal Code)

Phone: Home (____)________________ Work (____)_________________ Cell (____)________________

E-mail Address: ____

Date of birth: __________________________ Age: ________ Height: ________________
(Day / Month / Year)

Birth Place: ____________________________________ Weight: ________________

Gender: M or F (Please Circle) # of children: ________

Emergency Contact: ______________________________ ______________ (___)________________
(Name) (Relationship) (Phone)

Family physician: ___________________________ Referred by: __________________________________

What is your primary goal in having a reiki treatment?
____
____

Do you have any chronic illness or concerns? Yes No
If yes, please specify: ____

CURRENT MEDICATIONS:

Medication	Condition
______________________________	______________________________
______________________________	______________________________

HEALTH HISTORY

Please check any conditions you are currently experiencing or have experienced in the past.

P= Previous Ailment C= Current Ailment

P C HEAD & NECK
- ☐ ☐ Vision problems
- ☐ ☐ Eyeglasses/cont. lenses
- ☐ ☐ Earaches
- ☐ ☐ Sinus

P C OTHER
- ☐ ☐ Digestion difficulty
- ☐ ☐ Constipation
- ☐ ☐ Liver
- ☐ ☐ Kidney
- ☐ ☐ Bladder
- ☐ ☐ Gallbladder
- ☐ ☐ Diabetes, Type __
- ☐ ☐ Insomnia
- ☐ ☐ Epilepsy
- ☐ ☐ Cancer
- ☐ ☐ Arthritis

Doctor diagnosed: Yes/No

P C INFECTIONS
- ☐ ☐ Herpes
- ☐ ☐ Hepatitis
- ☐ ☐ Tuberculosis
- ☐ ☐ HIV/AIDS

Other: __________________

P C RESPIRATORY
- ☐ ☐ Chronic cough
- ☐ ☐ Smoking
- ☐ ☐ Shortness of breath
- ☐ ☐ Breathing problems

Explain: __________________

P C JOINT/MUSCLE PAIN
- ☐ ☐ Neck
- ☐ ☐ Shoulder L/R
- ☐ ☐ Upper Back
- ☐ ☐ Mid Back
- ☐ ☐ Low Back
- ☐ ☐ Hip L/R
- ☐ ☐ Leg L/R
- ☐ ☐ Knee L/R
- ☐ ☐ Foot L/R

Any previous dislocations? Y/N

P C SKIN
- ☐ ☐ Loss of sensation
- ☐ ☐ Bruise easily
- ☐ ☐ Allergies
- ☐ ☐ Skin conditions

What? ______________________

P C CARDIOVASCULAR
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Poor circulation
- ☐ ☐ Heart disease
- ☐ ☐ Phlebitis
- ☐ ☐ Stroke
- ☐ ☐ Varicose Veins

Doctor diagnosed: Yes/No

P C WOMEN ONLY

Are You Pregnant? Yes No
- ☐ ☐ Menstruation problems
- ☐ ☐ Breast discomfort
- ☐ ☐ Caesarian section
- ☐ ☐ Gynecological surgery

Date: _________________________

# of Pregnancies_______________

# of Children__________________

SURGERY:

Type: ____

Date: ____

Details: ____

INJURY (SPRAINS, FRACTURES, ETC):

Type: ____

Date: ____

Details ____

Please note: Your appointment time is your treatment time. **Please cancel appointments no less than 24 hours prior or a full fee will be charged.** The same applies for missed appointments.

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INFORMED CONSENT: REIKI

PLEASE READ THE FOLLOWING AND SIGN BELOW

I certify that the attached information is correct to the best of my knowledge. I acknowledge that Leslie Martin has my permission to provide the service of Reiki to me. I understand that I may refuse treatment at any time and I have been informed of risks, if any involved in this type of treatment.

I acknowledge that Leslie Martin is not a medical doctor or medical practitioner and therefore I take full responsibility and release Leslie from liability with respect to any advice or treatment/care, which I may follow. I understand that reiki is not for the purpose of diagnosing and does not take the place of a doctor's care.

I have read the above consent. I have also had the opportunity to ask questions about its consent and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Privacy Policy: Please review the attached **Privacy Policy Overview.** This policy has been written with the guidelines set out by the Privacy Commissioner of Canada. (Personal Information Protection and Electronic Documents Act).

________________________________ ________________________________

Patient name (print) | Signature of Patient or Legal Guardian

________________________________ ________________________________

Therapist Signature | Date