HEALTH HISTORY

Name: _____ Age: _____ Birthdate: _____
Address:_____City:_____St:_____Zip:_____
Email:_____
Phone: H:_____C:_____W:_____
Occupation:_____ Employer:_____
Marital Status:_____ Number of Children:_____ Ages:_____
Physician:_____ Phone:_____
Emergency Contact:_____ Phone:_____

Have you received Reiki or other Energy Healing therapy before? [ ] no [ ] yes When?_____
If yes, what type and what for? _____
What is the reason for this appointment? _____

Do you now or have you recently had any of the following conditions? (circle any that apply)

Cancer	Headaches	Hypertension	Anxiety	Anger
COVID-19	Fainting/Seizures	Hyperthyroid	Depression	Fear
Diabetes	Parkinson's	Hypothyroid	Emotional Pain	Feeling lost
Heart Disease	Polio	OCD/Addictions	Exhaustion	Sadness
Hepatitis	Numbness/Tingling	Physical Pain	Overwhelm	Suicidal thoughts

Details about above:_____
Any other illnesses or conditions?_____
Any allergies or sensitivities?_____
Are you taking any medications? [ ] no [ ] yes For what conditions? _____
_____
Any serious physical trauma? [ ] no [ ] yes Describe: _____
_____
Any serious emotional trauma? [ ] no [ ] yes Describe:_____
_____
Did you have a difficult birth? [ ] no [ ] yes Describe:_____
_____
Have you had any surgeries? [ ] no [ ] yes Date/Details:_____
Any serious head injuries? [ ] no [ ] yes Date/Details: _____
Have you fallen on your tailbone? [ ] no [ ] yes Date/Details:_____
Do you exercise or play sports? [ ] no [ ] yes _____ Hrs./wk._____
Do you do yoga or meditate? [ ] no [ ] yes Form:_____ Hrs./wk._____
Do you have a regular spiritual practice? _____
Are you intuitive, psychic, empathetic, or telepathic? _____
How is the quality of your sleep? Sleep like the dead / Great / Good / Poor / Just shoot me! Hrs./night_____
Do I have permission to touch you? [ ] no [ ] yes
To the best of my knowledge this information is correct.

Signature:_____ Date:_____

Parent/Guardian: Date: