

Therapist \_\_\_\_\_

**REIKI INTAKE FORM**

Date: \_\_\_\_\_

**Client Intake Form**

Name:	Home Phone:
Street Address:	Work Phone:
City, State Zip:	Cell Phone:
Email:	
Date of Birth:	Your Occupation:
Emergency Contact:	Phone:
Referred by: (Name of Referee, Flyer, Ad etc.):	

**Health / Medical History**

Are you seeing a health care professional?	Comment:
Are you taking any prescribed medications?	Comment:
Are you taking any supplements, herbs, over the counter medications, or known blood thinners?	Comment:
Do you have any known allergies?	Comment:

New Conditions (Are you experiencing, or do you have any of the following): Circle all that apply

- |                        |                             |                      |
|------------------------|-----------------------------|----------------------|
| Cold / Flu             | Burns / Sunburn             | Headaches            |
| Fever                  | Numbness / Tingling         | Panic Attacks        |
| Infections             | Skin Conditions             | Depression / Anxiety |
| Possible Pregnancy     | Sprains / Strains           | Digestive Disorders  |
| Arthritis / Tendonitis | Muscular/Skeletal Disorders |                      |

Have you ever been diagnosed with, or been advised to seek treatment for: Circle all that apply

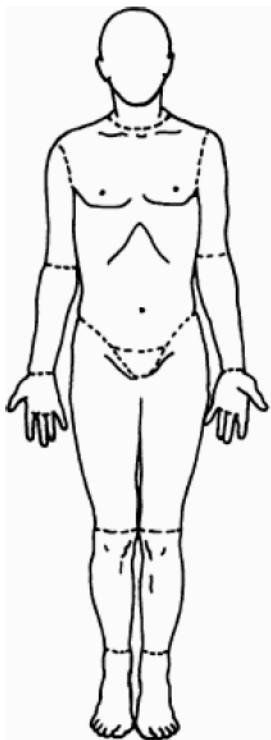
- |                           |                                 |                                |
|---------------------------|---------------------------------|--------------------------------|
| High / Low Blood Pressure | Liver / Gall Bladder Conditions | Diabetes / Low Blood Sugar     |
| Stroke                    | Aneurysm                        | Disc Disorders                 |
| Osteoporosis              | Lymphatic Conditions            | Nerve Disorders                |
| Heart Disease             | Cancer                          | Seizure Disorders              |
| Kidney/Bladder Conditions | Reproductive System Conditions  | Chronic Respiratory Conditions |
| Anemia/Blood Disorders    | Chronic Sinus Conditions        | Asthma                         |

Any other conditions not mentioned above?

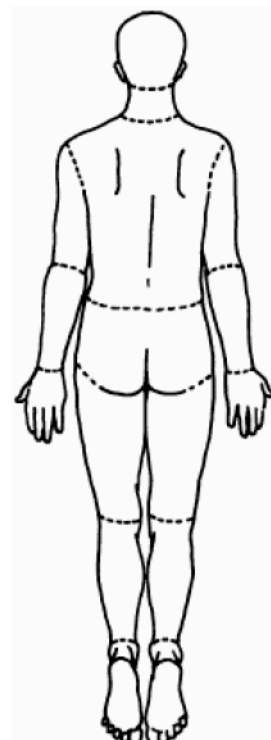
Is this your FIRST Reiki session?      YES      NO  
 If NO, when was your last session?

Have you ever had any:		
Hospitalizations and/or Surgeries	YES	NO
Accidents and/or Injuries	YES	NO
If Yes, Please Explain (Include Dates):		
Have you experienced trauma or emotional upset causing symptoms such as headaches, anxiety, sleep disturbance, digestive disturbance, etc.?		
YES	NO	
If Yes, Please Explain:		
What do you think is the general condition of your health?		
What hobbies, activities or recreation do you participate in?		
Are you able to lie on your back and stomach on a massage table for this session?    YES    NO    If No, Please Explain:		
TREATMENT REQUESTS: What specific body areas or emotional/mental concerns would you like to focus on today?		

On the following image, please mark any areas that may be causing physical discomfort.



Sharp and Stabbing = ++++  
 Dull and Achy = VVVV  
 Pins and Needles = XXXX  
 Numbness = ///



**Before your session, please read and sign below:**

I understand that Reiki is a relaxation and stress reduction technique. Reiki practitioners do not diagnose conditions, nor do they prescribe substances or perform medical treatment, nor interfere with treatment of a licensed medical professional. Reiki sessions provided are complimentary to and separate from medical services. I affirm that I have stated all known medical conditions, mental football betting odds and tips and/or physical ailments, as well as any current prescription medications. I agree that, prior to any session, I shall inform my practitioner of any changes in these conditions.

I also understand that reiki is an energetic healing methodology, which involves hand-touch to heal. I understand that I will be fully clothed during the session, and experience a series of "safe touch" hand positions on and above my body.

Information exchanged during a Reiki session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion. I understand that all communication between the practitioner and myself, verbal/written, shall be kept confidential.

Payment is due when services are rendered unless other arrangements have been made prior to my appointment. I will give 24 hour notice when possible if I cannot keep a future appointment.

**Cancellation Policy**

**Life happens:** If you need to miss your hour of BlissBlissBliss, please call or e-mail us (304-413-0270, [staff@theblissblissbliss.com](mailto:staff@theblissblissbliss.com)) as soon as you know that you will miss your scheduled appointment. Your consideration allows us to manage our schedules.

We encourage a 24 hour notice if you cannot keep an appointment.

\$0 is charged if you call to cancel 24 hours in advance of your appointment.

The price of the full scheduled visit will be charged if you do not call and do not show up for your appointment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Membership AutoPay Agreement**

Between: \_\_\_\_\_ and BlissBlissBliss for:  
(Client Name)

- Twelve (12) 1 hour treatments- \$49.00 per visit
- Six (6) 1 hour treatments - \$55 per visit

Contract Start Date: \_\_\_\_\_ Contract End Date: \_\_\_\_\_

Contract Duration and Automatic Renewal: Contract is in force for \_\_\_\_\_ months from the Contract Start Date, with automatic renewal for subsequent months, unless cancelled by either \_\_\_\_\_ or BlissBlissBliss, with (Client Name) notification of 30 days in advance of the next billing date.

Agreement to Pay Recurring Fees: \_\_\_\_\_ agrees to pay BlissBlissBliss recurring fees as follows:

Annual Membership fee of \$10.00. This annual fee will automatically occur every 12 months.

Monthly Body Work fee of \$\_\_\_\_\_ via Client authorized automatic credit card or checking account ACH charges. Alternatively, Client may prepay six or twelve months in advance via any credit card, bank check or cash. Payment in monthly increments by any means other than Client's credit card or ACH is not permitted.

Please read and sign below:

- (a) I agree to purchase the BlissBlissBliss Membership for \$10.00 as an automatic, annual charge to my credit card, or automatic debit to my checking account.
- (b) I agree to purchase the BlissBlissBliss Body Work Treatments Package for \$\_\_\_\_\_ as an automatic, charge to my credit card, or automatic debit to my checking account each month for a contract period of \_\_\_\_\_ months.
- (c) I hereby certify that I am the holder of the credit card, or an authorized signer on the bank checking account detailed below.
- (d) I understand that my membership will be deactivated if my account becomes more than 30 calendar days late.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **BlissBlissBliss Membership Plan Savings Opportunity:**

We believe that body/energy work is a fundamental component of wellness and our guest prices are designed to support your choice in getting body/energy work. The BlissBlissBliss Membership Plan allows clients who choose to come more frequently, the opportunity to gain additional savings on each body/energy work session.

Membership Plans if not paid in full are set up on autopay system. The membership fee will be charged monthly on the 1<sup>st</sup> of the month. Sessions on a membership plan are to be used within one year of the start of the membership.

### **Membership Options:**

- Twelve (12) 1 hour basic treatments - \$49.00 per visit (\$588)
- Six (6) 1 hour basic treatments - \$55 per visit (\$330)

A \$10 yearly membership fee will be charged for all memberships.

Basic treatments are: Swedish, pregnancy massage, Thai Yoga massage, & Reiki.

I understand that should I decide during my membership year to not remain with BlissBlissBliss, my actual visit history will be recalculated and I will pay BlissBlissBliss the difference between my intended plan with actual visits.

### **Pay As You Go Memberships Offered Through Autopay**

We offer the following Pay-As-You-Go through a monthly auto pay plan to our members:

- Twelve (12) - 1 hour treatments \$49.00 per visit charged monthly on the 1<sup>st</sup> of the month for 12 months.
- Six (6) 1 hour treatments \$55 per visit charged monthly on the 1<sup>st</sup> of the month for 6 months.

I understand that should I decide during my membership year to not remain with BlissBlissBliss, my actual visit history will be recalculated and the actual amount due will be taken from the last visit fee. Any No Show Fees or Skipped Visits may also be charged.

### **Cancellation Policy**

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\$0 is charged if you call to cancel 24 hours in advance of your appointment.

The price of the full scheduled visit will be charged if you do not call and do not show up for your appointment.

**\*\*\*Customer Copy Please tear off last page and keep for your reference\*\*\***