AcuReiki Healing Arts

Initial Visit Client Questionnaire – AcuReiki Essence©

NAME _____ DATE _____
ADDRESS _____ PHONE #_____
Name of Emergency Contact _____ PHONE#_____
EMAIL ADDRESS _____ DOB: _____
(Email will only be used for communication regarding appointments, etc.)

Occupation: _____ Are you a fulltime student? Yes No
What would you like to focus on this session? _____
Are you currently under the care of a physician? YES NO If Yes, for what condition(s)
_____
Are you currently ill or recovering from an illness? YES NO If yes, please indicate symptoms, onset, duration and current status. _____

Are you allergic to any nuts, flowers, or seeds or essential oils? YES NO If Yes, which ones?
_____

Do you currently have any of the following: ____ cysts/tumors ____ severe fluid retention ____ fever
___ bruising ____ sprained or strained muscles/tendons ____ exhaustion/chronic fatigue
___ cancer ____ acute infection ____ blood clot ____ perforated ulcer ____ wound
___ dizziness ____ heart condition ____ other _____
___ tendonitis (chronic) ____ rheumatoid arthritis ____ other autoimmune condition?
___ osteoarthritis (if yes, which joints are affected? _____

MEDICAL HISTORY
Have you ever had an illness requiring hospitalization or surgery? YES NO
If yes, please describe the condition, the onset, duration and resolution _____
_____

Have you ever had a serious injury (such as broken bones, concussion, trauma)? If yes, please describe the type of injury, how long ago it occurred, and its resolution._____
_____
Do you have autoimmune condition(s)? If yes, what type(s)? _____
Symptoms: _____
Onset of condition(s): _____ Medications? _____
Resolution? _____ Side effects? _____

Have you had any pregnancies?_____ If yes, how many? _____ Complications? _____

Medications
Are you currently taking any prescription medications other than any mentioned above (including birth control pills)? YES NO If yes, please provide information below.

Name of Medication	Reason for the Medication	Any side effects?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any supplements, vitamins, herbs, homeopathic remedies, etc.? YES NO
(If yes, please list) _____

Have you recently taken antibiotics? _____
Do you have any allergies or hayfever? If yes, please check the relevant symptoms:

_____ sneezing "fits"	_____ irritated bronchi, dry cough	_____ sore throat
_____ congested sinuses	_____ nonproductive "dry" pressure in sinuses	_____ itchy, irritated eyes
_____ skin rash	_____ wheezing, asthma	_____ itchy skin

FOR WOMEN
Do you still have menstrual periods? YES NO If yes, are your cycles regular? _____
How many days in your cycle? _____ If menses has stopped, when was your last period? _____
Do you have any pain or difficulties during your cycle?_____
If you are in perimenopause or menopause, are you experiencing any symptoms? _____
_____

Systems of Elimination
Do you have any problems with urination? YES NO If yes, describe_____

Do you experience any of the following on a regular basis (please circle): constipation diarrhea
nausea stomach irritation food sensitivities bloating gas pain burping
burning sensations when eliminating heaviness in stomach stomach slow to empty

Energy/Vitality
Do you have trouble sleeping? _____ If yes, how often _____
Do you have trouble falling sleep? ____ Do you go to sleep easily and then wake up too early? _____
Once you wake up, are you able to go to sleep again? _____
Do you wake up at the same time(s) each night? _____

Do you feel warm or cool generally, physically? _____
Cold hands and/or feet? Heat in the palms of the hands and soles of the feet? _____

What type of physical activities do you do during the day (such as sitting at a computer, stand for long periods, lift heavy objects, etc.) _____

FIVE ELEMENT/ACUPRESSURE INFORMATION
Indicate with one checkmark if you experience a condition occasionally; use two checkmarks for those which occur often, and 3 checkmarks if the condition is a major concern.

WATER ELEMENT	WOOD ELEMENT	FIRE ELEMENT/PITTA
___ hearing loss	____ headaches, migraines	____ skin rashes
___ dizziness	____ endometriosis	____ gum problems
___ low backache/neck pain	____ dry, red eyes	____ itching/burning skin
___ blue/black circles under eyes	____ greenish circles under eyes	____ redness under eyes
___ aversion to cold	____ irritability, anger	____ aversion to heat
___ weakness of legs/knees	____ weak, stiff tendons	____ facial redness
___ low energy 3-5pm	____ insomnia 11pm-3am	____ night sweats
___ emotional instability	____ lax joints	____ heart palpitations
___ loss of concentration	____ fullness below ribs	____ dark urine
___ thyroid problems	____ indecisive	____ bitter taste in mouth
___ hair loss/thinning	____ shoulder/neck tension	____ infections
___ fearful	____ anxious	____ hysteria or volatile
___ depression, lethargy	____ jaw tension	emotions
___ indecisive	____ poor circulation	____ diarrhea
___fatigue, exhaustion	____ competitive, driven Type A	____ infections

___ excessive sleeping
___ water retention/edema

____ PMS, cramps
____ Heavy periods, "flooding"

____ arthritis
____ inflammation

EARTH ELEMENT/KAPHA

___ indigestion
___ flatulence
___ food allergy
___ brown circles under eyes
___ nausea, especially between 7-9am
___ weak or strong appetite
___ anemia
___ bad taste in mouth
___ craving sweet taste
___ aversion to yellow
___ sinus headache
___ subcutaneous cysts
___ aversion to dampness
___ frequent colds
___ nausea, prolonged fullness after eating
___ accumulation of fat
___ mucus conditions
___ heaviness, inertia

METAL ELEMENT

____ bronchitis
____ asthma
____ shallow breathing
____ white circles under eyes
____ sinus congestion
____ nasal infection
____ frequent colds
____ wake up between 3-5am
____ dry skin / hair
____ sadness/grief
____ constipation
____ gas, bloating

REIKI:

Have you ever had a Reiki session before? YES NO

Is there anything about prior Reiki, acupressure, or other bodywork that you particularly liked or disliked?

TONGUE/PULSES/NOTES (office use only)

DISCLAIMER, WAIVER & RELEASE
AcuReiki and/or AcuReiki Essence© Sessions

Please be advised that:

- Information given in Acupressure and/or Reiki session is for educational purposes, and that it is not a substitute for medical or psychological diagnosis and treatment.

- Acupressure Therapists ("ATs") and Reiki practitioners ("RPs") do not diagnose conditions nor do they prescribe, administer or recommend controlled substances and drugs that might be prescribed by a licensed practitioner.

- Essential oils are concentrated herbal oils and are only applied as a single drop to an acupressure point in AcuReiki Essence© sessions. They are not ingested or used in massage oil in session.

- AT and RPs do not perform medical treatment or interfere with the treatment of a licensed medical professional. It is recommended that you see a licensed physician or licensed health care professional for any physical or psychological concerns. You have the right to choose to go to a licensed provider of healthcare.

It's important to note that Acupressure and Reiki modalities fall under a voluntary licensing process in the State of California. That licensing body is CAMTC (California Massage Therapy Council. I have a license through CAMTC. Anything said in the course of the session is to educate you about Traditional Chinese Medicine ("TCM") concepts used in Acupressure and to further familiarize you with the nature of Reiki. Nothing said during sessions should be construed as medical advice.

Your AcuReiki or AcuReiki Essence© session may include the following:

- Completion of a detailed client intake form, which consists of providing your contact and emergency information, medical history, and a description of your current concerns (if any).

- An introduction to the basic concepts of TCM as they may relate to your concerns, and you may be shown specific Acupressure points you can press at home to support the work done in session.

- An explanation of the energetics of herbs, and how different herbs recommended for the same health problem might be more or less effective because of their energetics. I do not sell herbs or supplements, and if I feel you would benefit from TCM herbs, I will refer you to one or two acupuncturists I know who have an extraordinary understanding of herbs. It is strongly recommended that you discuss any herbs with your licensed healthcare provider before purchasing or taking them. This is especially important in terms of contraindications and possible drug interactions.

If at any time during the session you feel discomfort, please let me know.

I, _____, have read the foregoing, understand it and agree to it.
(Please print your name)

CLIENT'S SIGNATURE _____

DATE _____

SIGNATURE OF PARENT IF CLIENT IS UNDER THE AGE OF 18: _____