

# Divine Healing, Reiki and Coaching

## Client Intake Form

*(Confidential – Your information will never be shared without your consent)*

### Contact Information

Full Name:	Date of Birth:
Address:	
City/State/Zip:	
Phone:	Email:
Preferred Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text	
Emergency Contact Name & Phone:	

### Reason for Visit

What brings you to Divine Healing, Reiki and Coaching at this time?	
What do you hope to achieve from your Reiki and/or Coaching sessions?	

### Health & Wellness Background (Reiki & Coaching use only)

Are you currently under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what condition(s)?
List any medications, supplements, or herbal remedies:	
Check any that apply:	
<input type="checkbox"/> Stress/Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Fatigue	
<input type="checkbox"/> Insomnia <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Digestive Issues	
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Recent Surgery <input type="checkbox"/> Pregnancy	
<input type="checkbox"/> Other:	

### Energy Healing Experience

Have you ever experienced Reiki or other energy healing before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please describe:	

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***Lifestyle & Emotional Wellbeing (Optional but helpful)***

How would you describe your stress level? <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	
Do you practice meditation, yoga, or mindfulness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Significant life changes or challenges right now:	

***For Coaching Clients***

Specific goals or challenges to focus on:	
Have you worked with a coach before? <input type="checkbox"/> Yes <input type="checkbox"/> No	

***Consent & Agreement***

I understand that Reiki and Coaching are complementary therapies and do not replace medical diagnosis or treatment. My p	
Signature:	Date:

***Practitioner Notes (Office Use Only)***

Session Date(s):	
Observations/Follow-Up:	