



Client Disclosure & Intake Form

A copy of this disclosure statement will be kept on file for at least two years after the last date of service.

As my client, you should discuss any recommendations I may provide with your Primary Care Physician, Obstetrician, Gynecologist, Oncologist, Cardiologist, Pediatrician or Pediatric Health Care Provider, or other Board-Certified Physician.

Client Information

Your Name: _____
Occupation: _____
Date of First Visit: _____ **Date of Birth:** _____
Email: _____ **Phone:** _____

Address

Address Line 1: _____
City: _____ **State:** _____ **Postal Code:** _____
Country: _____

Session Information

Reason for Seeking Reiki Session:

Desired Outcomes or Goals:

Previous Experience with Reiki:



Practitioner Disclosure

As a Complementary and Alternative Health Care Practitioner, I am **not licensed, certified, or registered by the State of Colorado** as a health care professional. I am **not a licensed medical physician** and do not diagnose, treat, or prescribe remedies for the treatment of disease.

The services I perform, whether in person, by mail, or by phone, are at all times **restricted to complementary and alternative health care services** intended for general well-being. I am **prohibited from performing:**

- Surgery or any invasive procedure
- Administering or prescribing x-ray radiation
- Prescribing prescription drugs
- Using general or spinal anesthetics
- Administering ionizing radioactive substances
- Using a laser device that punctures the skin
- Performing enemas/colonics unless board certified
- Practicing midwifery
- Practicing psychotherapy
- Performing spinal manipulation
- Practicing optometry
- Directly administering medical protocols to a pregnant woman or a person who has cancer
- Practicing dentistry
- Setting fractures
- Practicing massage therapy
- Providing a conventional medical disease diagnosis
- Recommending the discontinuation of a course of care recommended by a health care professional

Consent for Minors (Ages 2-8)

I am also prohibited from treating children under the age of two. In order to treat a child between **ages 2-8**, I must have **written, signed consent from the child’s parent or legal guardian.**

Name of Child: _____ (Age: ____)

Signature of Parent/Legal Guardian: _____

Client Acknowledgment

I acknowledge that I have read and understand the information provided above.

Client Signature: _____ **Date:** _____