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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Click here to enter text.Attribute Questionnaire for Reiki **Name:** Click to enter name. **Date: Click to Enter Date** **YOUR PHYSICAL HEALTH**How would you rate your current state of physical health? [ ]  Excellent [ ]  Good [ ]  Average [ ]  PoorExplain any challenges (physical, mental, relationship, etc.) you are presently experiencing, if any:

|  |
| --- |
| Click here to enter text. |

Are you under the current consistent care of a physician? [ ]  Yes [ ]  NoIf yes, briefly explain:

|  |
| --- |
| Click here to enter text. |

 Physician(s) (Optional) Type of Services How Long?

|  |  |  |
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| Click here to enter text. | Click here to enter text. | Click here to enter text. |
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Are you taking over-the-counter or prescription medications? [ ] Yes [ ] NoIf yes, please list and explain any side effects you are experiencing, if any:Medications Use Frequency Side effects

|  |  |  |
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Holistic Therapies Check the following modalities that you have experienced*Whole Medical Systems Manipulative and Body-Based Mind-Body Medicine*[ ]  Homeopathy [ ]  Acupressure or [ ]  Art Therapy[ ]  Osteopathic Medicine Jin Shin Jyutsu or Shiatsu [ ]  Color Therapy[ ]  Acupuncture [ ]  Guided Imagery Biologically *Based Practices* [ ]  Alexander Technique or [ ] Hypnotherapy or Psychological[ ]  Biofeedback Feldenkrais Method Counseling[ ]  Herbal Therapy [ ]  Physical Therapy [ ]  Meditation[ ]  Hydrotherapy [ ]  Aromatherapy [ ]  Music Therapy[ ]  Nutritional Counseling [ ]  Breema Bodywork [ ]  Neuro-Linguistic Programming[ ]  Chiropractic Medicine [ ]  T’ai Chi[ ]  Cranial Osteopathy or [ ]  Yoga*Energy Medicine* Cranio-Sacral Therapy[ ]  Qi Gong [ ]  Lymphatic Therapy *Other:*[ ]  Healing Touch [ ]  Massage [ ]  Magnetic Therapy [ ]  Trigger Point Therapy or [ ]  Reiki Neuromuscular Therapy [ ]  Therapeutic Touch   |  |
|  |  |  |

Attribute Questionnaire for Reiki

For those holistic modalities that you are currently experiencing:

Modality When was your last session Number of sessions

|  |  |  |
| --- | --- | --- |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
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Do you feel your current modalities are appropriately addressing your needs? [ ]  Yes [ ]  No

If no, briefly explain.

|  |
| --- |
| Click here to enter text. |

**LIFE ACTIVITIES**

[ ] SINGLE [ ] MARRIED Number of CHILDREN: # MALE # FEMALE

CURRENT OCCUPATION: Click here to enter text. For how long? Click here to enter text.

ANY PREVIOUS OCCUPATIONS:

|  |
| --- |
| Click here to enter text. |

 WHAT ARE YOUR HOBBIES OR WHAT DO YOU ENJOY DOING IN YOUR FREE TIME?

|  |
| --- |
| Click here to enter text. |

WHAT COLOR(S) TEND(S) TO BE YOUR FAVORITE?

 [ ]  Red [ ]  Pink

 [ ] Purple [ ]  Lavender

 [ ]  Deep Blues [ ]  Light Blues

 [ ]  Black [ ]  Gray

 [ ]  Oranges [ ]  Yellow

 [ ]  Greens [ ]  White

Continue to Page 3

Attribute Questionnaire for Reiki

**WHAT ARE THE THINGS IN LIFE THAT BRING YOU JOY?**

|  |
| --- |
| Click here to enter text. |

**WHAT DO YOU FIND MAKES LIFE DIFFICULT?**

|  |
| --- |
| Click here to enter text. |

**DO YOU HAVE A PREFERENCE TO BE WITH PEOPLE OR ENJOY TIME ALONE?**

|  |
| --- |
| Click here to enter text. |

**ARE THERE ANY EMOTIONAL, MENTAL OR SPIRITUAL ISSUES THAT YOU ARE EXPERIENCING OR WORKING THROUGH THAT YOU WOULD LIKE TO ADDRESS IN YOUR SESSION?**

|  |
| --- |
| Click here to enter text. |

**ANY OTHER INFORMATION YOU WOULD LIKE TO SHARE ABOUT YOURSELF OR ANY SPECIAL REQUESTS:**

|  |
| --- |
| Click here to enter text. |