



Medical Reiki Intake Form

First Name: _____ Last Name: _____ Date of Birth (MM/DD/YYYY): _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Cell: _____ Email: _____

Emergency Contact: _____ Occupation: _____

Doctor's Name & Contact: _____

How did you hear of Visionary Health? _____

Please list your health concerns/Intentions for today:

Are you currently being treated by any other physician(s) or healthcare practitioner or specialist? Yes No
If yes, please elaborate.

Are you currently taking medications: Yes No
(Please list all of your prescription and non-prescription medications including birth control and aspirin, etc.)

Are you currently receiving other alternative treatments? Yes No If yes, what type ie (Homeopathy, acupuncture etc?)

Do you or have you ever suffered from seizures of any sort? Yes No If yes, please elaborate

Do you or have you ever suffered from seizures of any sort? Yes No If yes, please elaborate

Are you okay being touched "appropriately" during the Reiki session or do you prefer not to be touched at all?
Touch is okay prefer not to be touched (inappropriate touch of any kind by Reiki practitioner or client is a breach the Reiki Code of Ethics *

I understand that Reiki is a stress reduction and relaxation technique. I acknowledge that sessions administered are only for the purpose of helping me relax and to relieve stress. Reiki Practitioners do not diagnose conditions, nor do they prescribe substances or perform medical treatment, nor interfere with the treatment of a licensed medical professional for any physical or psychological ailment or condition I may have.

I also understand the body can heal itself and do so complete relaxation is often beneficial. Long-term imbalances in the body require multiple sessions to allow the body to reach the improvement requires commitment on my part, and that I must be willing to change in a positive way if I am to receive the full benefit of Reiki.

I acknowledge my commitment to my self-improvement process. I recognize that a Reiki session program must be followed to be truly effective, just as prescribed medication is only effective if taken as directed.

Name _____
Signature _____

Date _____

INFORMED CONSENT- MEDICAL REIKI (Also Known as "Usui reiki Ryoho")

TO THE CLIENT: You have the right, as a client, to be informed about the recommended procedure to be used so that you make an informed decision whether to undergo the recommended procedure(s) after knowing the benefits and risks involved. This document is not meant to alarm you; it is simply to inform you.

If you refuse any special procedure this will not affect your receiving other care or future treatments.

- I understand that the course of care, therapy may include the use of multiple modalities or therapies offered by Beatriz Marin at the 5359 Dundas St West Unit 108, Toronto, Ontario, M9B 1B1.
- I understand Reiki is a natural method of energy balancing for the purpose of stress reduction and relaxation. It can involve "the laying on of hands" although this is not required for Reiki to be effective.
- While it can be used entirely on its own, it is not meant as a substitute for medical, or psychological, diagnosis and treatment. In fact, it can readily compliment other forms of therapy.
- Practitioners do not diagnose conditions, nor do they perform medical treatment, prescribe substances, or interfere with the treatment of a licensed medical professional, unless they have received training in such a licensed professional practice that supports this. (This type of skill is not a part of a normal certified Reiki training program).
- Should not compete with medical doctors and their treatments.
- Can be used together with any other form of medical, natural, or alternative therapy to compliment it.
- I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive therapies.
- I waive the option of signing consent to treat for each special procedure at each treatment date.
- I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time.
- I understand that I have the right and the opportunity to ask questions about my condition & discuss therapies
- I understand that there is payment for today's treatment, and subsequent follow-ups, at the time of service accordingly to the fee schedule or plan.
- I understand that a phone consultation fee may apply.
- I accept that a missed appointment Fee of \$50 will be charged and any missed appointments or cancellations within 24 hours of the appointment and that all outstanding invoices will need to be paid before the next appointment.
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I give consent and authorize Visionary Health Medical Educational Clinic practitioners to be contacted in the near future, for continued care.
- I understand that in the event there is a chance that media, audio or visual or published information, all of which I am consenting that Visionary Health Medical Educational Clinic be able to use and will be informed to their best practices ethics.
- I authorize Visionary Health Medical Educational Clinic team to contact me for educational events, promotions, incentives, newsletters, engagements, or information regarding of any health benefit.
- I certify that I have read this form or have had it read to me, and that I understand its content and meaning. I have sufficient information to give this informed consent.

Note: It is recommended you see a licensed physician or licensed health care professional for any physical or psychological ailment you may have.

Patient Name (please print): _____

Patient Signature: _____ Date: _____



Visionary Health Medical Educational Clinic (VHMEC)
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