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| PERSONAL INFORMATION  Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of birth (dd/mm/yy):\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_  /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Type of job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| EMERGENCY CONTACT  Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Link: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| INFORMATION   1. Have you ever received a therapeutic or energy care? ……..………………………..……..   If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Are you undergoing other therapeutic care? ……….…………………………………………….   If so, what care and frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do you have health insurance? ……………………………………………………………….…………   If so, do you want a receipt in naturopathy? \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do you have a family doctor? ……………………………………………………………….…………..   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Are you particularly sensitive to touch? ……………………………………………………………   If so, do you have a particular health condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you been referred by someone? ..................................................................   If so, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Yes * Yes * Yes * Yes * Yes * Yes | * No      * No * No * No * No * No |
| 1. What activities or leisure do you practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| AUTORISATION   1. I would like to receive occasional information about the services via e-mail? 2. Are you a minor age less than 18 years. If so, add the name of the adult present and signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Yes * Yes | * No * No |
| RESERVED FOR THE PRACTITIONNER  Name : Caroline Paré Number of visits : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| HEALTH INFORMATION   |  |  |  |  | | --- | --- | --- | --- | | **Conditions – please check if it is CURRENTLY a concern or if it has affected you IN THE PAST.** | Currently | In the past | Precisions: | | Accident |  |  |  | | Allergies |  |  |  | | Cancer |  |  |  | | Cardiovascular disease |  |  |  | | Circulatory disorders |  |  |  | | Digestive disorders |  |  |  | | Emotional or mental disorders |  |  |  | | Hearing disorders |  |  |  | | Eating disorders |  |  |  | | HIV/ Aids |  |  |  | | Muskuloskeletal disorders |  |  |  | | Neurological or brain disorders |  |  |  | | Pregnancy |  |  |  | | Respiratory or pulmonary disorders |  |  |  | | Skin disorders |  |  |  | | Sleep disorders |  |  |  | | Surgeries |  |  |  | | Vision disorders |  |  |  | | Others |  |  |  | | Medication (1) |  |  | Reason: | | Médication (2) |  |  | Reason: | |
| UNDERSTANDING – Please initial each of the following statements:  \_\_\_\_\_ …I understand that Reiki is a gentle, energetic and hands-on approach;  \_\_\_\_\_ …I understand that the practitioner does not diagnose conditions nor prescribe or perform medical treatment;  \_\_\_\_\_ …I understand that energy work does not replace medical care and care offered by other health professional;  \_\_\_\_\_ … I understand that medication, dosage is entirely under the responsibility of your doctor;  \_\_\_\_\_ …I understand that I am responsible for pursuing necessary care with a doctor and/or psychologist as needed;  \_\_\_\_\_ … I understand that I am receiving this treatment out of my own choice;  \_\_\_\_\_ …I understand that through hypnosis and relaxation the body may improve in certain aspects;  \_\_\_\_\_ …I understand that under hypnosis I continue to be conscious of my choices and free will;  \_\_\_\_\_ … I understand the practionner has a right to refuse to treat a client;  \_\_\_\_\_ …I understand this approach may require several sessions; Appointments must be cancelled 48 hours in advance;  \_\_\_\_\_ …I understand this treatment is a service for which I will pay the due amount.  Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |