

REIKI
at HEALING HANDS CHIROPRACTIC, LLC

CONFIDENTIAL HEALTH ENTRANCE FORM

Full Name _____ Date _____

Please list reasons below for pursuing reiki therapy today:

Primary Reason:

Secondary Reason:

In order for us to better understand your current level of health, please circle any of the body signals which you have or have had previously:

Allergies	Ear Infection	Menopausal Problems
Arthritis	Frequent Cold/Flu	Menstrual Problems
Asthma	Headaches	Prostate Trouble
Bladder Problems	High Blood Pressure	Postural Imbalance
Dizziness or fainting	Intestinal Problems	Short Leg/Orthotics
		Sinus Problems

Please circle the following conditions that you have or have had:

Alcoholism	Cancer	Diabetes	Epilepsy
Hyper/Hypothyroidism	HIV	Heart Disease	Lung Disease
Multiple Sclerosis	Scoliosis	Stroke	Ulcers
Other _____			

Please circle the conditions that are common to family members:

Alcoholism	Cancer	Diabetes	Epilepsy
Hyper/Hypothyroidism	HIV	Heart Disease	Lung Disease
Multiple Sclerosis	Scoliosis	Stroke	Ulcers
Other _____			

Known list any known allergies:

I certify that the above information is accurate. Any questions that may have occurred to me have been answered to my satisfaction.

Signature _____ **Date** _____