



Energy Health & Wellness LLC

Michele Dellavalle, CHTP, RMT, CH

(908) 403-2045

Reikiehw.com

Client Information:

Name: _____

Address: _____ City/State/Zip _____

Telephone: (Circle your preferred contact method)

Home # _____ Work# _____ Cell # _____

Email: _____ Occupation/Student: _____

Birthday: _____ Age: _____

Marital Status: Single Married Life Partner Divorced Widowed

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

How did you hear about us? _____

Can we include you on our mailing list? Yes No

Purpose of Visit:

Reiki Healing Touch Crystals Crystal Grid *Hypnosis

Have you tried other alternative therapies in the past? (Circle) Yes No

Which one(s): _____

What Purpose? (General Wellness, Pain, Stress, Anxiety, High Blood Pressure, Etc.)

Current Stress Level (Scale of 1 – 10 with 10 being the highest): _____

* Hypnosis Sessions require an initial consultation & other Forms to be filled out that are located on website under Forms.

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Health Information:

Physician/Health-care Provider:

Name: _____ Phone: _____

Current Medicines and Dosages:

Major Complaints or Area of Concerns:

- 1) _____
- 2) _____
- 3) _____

How long have you experienced this condition? _____

Medical History:

Allergies ___ Stress ___ Anxiety ___ Cancer ___ Emotional Disorders ___
Thyroid Disease ___ Heart Disease ___ HIV/Aids ___ High Blood Pressure ___
Fibromyalgia ___ Other Autoimmune Disorders ___ ADHD ___

Other: (please specify) _____

Further Explanation, if applicable: _____

Are you sensitive to perfumes or fragrances? (Circle) Y N

Are you sensitive to touch? (Circle) Y N

Do you have any concerns related to your session or is there anything else we should know?

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Acknowledgements:

I understand that **Reiki and/or Healing Touch**, is a simple, gentle, hands-on energy technique that is used for stress reduction and relaxation. I understand that Reiki practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. I understand Reiki does not take the place of medical care. It is recommended that I see a licensed physician or licensed health care professional for any physical or psychological symptoms or ailments I may have. I understand that Reiki can complement any medical or psychological care I may be receiving. I also understand that the body has the ability to heal itself and to do so, complete relaxation is often beneficial. I acknowledge that long term imbalances in the body sometimes require multiple sessions in order to facilitate the level of relaxation needed by the body to heal itself.

_____ Initial

AND/OR

I understand that Crystal Healing is a simple, gentle, vibrational energy technique utilizing crystal on or near the body that is used for stress and relaxation. I understand that Crystal Healing practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with treatment of a licensed medical professional. I understand that Crystal Healing does not take the place of a medical care. It is recommended that I see a licensed physician or a licensed health care professional for any physical or psychological ailment I may have. I understand that Crystal Healing can complement any medical or psychological care I may be receiving. I also understand that the body has the ability to heal itself and to do so, complete relaxation is often beneficial. I acknowledge that long term imbalances in the body sometimes require multiple sessions in order to facilitate the level of relaxation needed by the body to heal itself.

_____ Initial

AND/OR

I acknowledge that recommendation(s) and/or referral(s) of services, whether those services are performed by Energy Health & Wellness LLC practitioner, Michele Dellavalle, or another licensed or unlicensed practitioner, are services that I will choose freely to participate in; and am in no way compelled to participate or receive services by virtue of the recommendation(s) and/or referral(s).

_____ Initial