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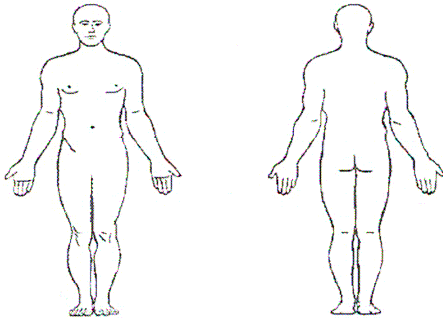
Confidential Client Intake – No information will be sold, rented or shared with outside parties without your consent and only in the event of medical or billing necessity. Your privacy is important to me!

Name _____ Email _____
 Street Address _____ City, State and Zip _____
 Birth date _____ Home Phone _____ Work/Cell Phone _____
 Emergency Contact _____ Relationship _____ Phone _____
 Is there someone I may thank for your referral? _____ Phone _____

Please circle if you have, or have had any of the following:

Heart Disease, High Blood Pressure	Cancer, Lumps or Growths	Headaches/Migraines
Depression, Anxiety	Varicose Veins, Phlebitis, Blood Clots	Autoimmune Disorder
Chronic Fatigue, Insomnia	Chronic Pain or Illness	Current or recent Pregnancy
Diabetes, Kidney Problems	Allergies to scents/oils	Recent Illness/Injury – Please List
Arthritis, Joint Problems	Contagious Skin Disorders	_____

Please indicate areas of pain below:



Relevant surgeries/injuries/major illness and dates of occurrence:

Specific conditions you are currently under medical care for:

Please provide name/phone of caregivers for above conditions:

Current medications or natural remedies: _____

To better understand you and your self-care practices, please answer the following questions. (Optional but helpful)

What is the main source of stress in your life? _____
 How do you usually cope with stress? _____
 Where do the effects of stress manifest in your body? _____
 How often do you take time out for your own personal enjoyment, enrichment or relaxation? Daily Weekly Monthly

Have you had therapeutic massage, or energetic healing before? _____ Last session? _____ How often? _____
 Are there any areas of your body, which require extra attention today? _____
 Are there any areas of your body you would rather have avoided? _____
 Which areas of your body do you give permission to have work done? (Circle)
 All or specifically Back Neck Head Face Arms Hands Legs Feet Buttocks Abdomen Chest

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones; and massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. ***Please be advised: without 24 hours notice, cancelled or missed appointments will be charged the full rate of the missed session.***

Signature _____ Date _____