CONFIDENTIAL CLIENT CASE HISTORY AND INTAKE FORM

NAME:	DATE:
ADDRESS:	PHONE:
POSTAL CODE:	EMAIL:
DATE OF BIRTH:	REFERRED BY:
WOULD YOU LIKE TO RECEIVE UPDATES VIA EMAIL?	

PRIMARY CONCERNS:	LEVEL: 1 (HARDLY NOTICE SYMPTOMS) TO 10 (SYMPTOMS ARE UNBEARABLE):

A:	LEVEL:
B:	LEVEL:
C:	LEVEL:

MEDICATIONS/REMEDIES/SUPPLEMENTS & REASON FOR TAKING:
SIGNIFICANT ACCIDENTS/INJURIES:

R E I K I BY JOHN MOTHERSHEAD

PLEASE PLACE AN X BESIDE ANY CONDITIONS THAT APPLY (PAST OR PRESENT):

CANCER:	VARICOSE VEINS:	ALLERGIES:
HEART DISEASE:	H/L BLOOD PRESSURE:	SURGERY:
DIABETES:	PARALYSIS:	GENETIC DISORDERS:
STROKE:	TMJ DYSFUNCTION:	PHOBIAS:
EPILEPSY:	ARTHRITIS:	

PLACE AN X BESIDE ANY SYMPTOMS THAT YOU EXPERIENCE:

HEADACHE	HEAVY FEELING IN LIMBS	COLD IN HANDS AND FEET
FAINTNESS/DIZZINESS	BLURRINESS OF VISION	LOWER BACK PAIN
TIGHTNESS IN JAW	CONSTIPATION	SHOULDER/NECK PAIN
WEAK BODY PARTS	LOOSE BOWEL MOVEMENTS	CARPEL TUNNEL SYNDROME
SMOKING (#/DAY__)	IRRITATED BOWEL	MENSTRUAL IRREGULARITIES
NERVOUSNESS	PAINS IN HEART/CHEST	OTHER:
POOR APPETITE	INDIGESTION	
EXCESSIVE URINATION	INSOMNIA	
GRINDING OF TEETH	FATIGUE	ARE YOU PREGNANT?

PLACE AN X BESIDE ANY AREAS BELOW THAT YOU WOULD LIKE IMPROVEMENT IN:

NEGATIVE SELF-TALK, SELF-SABOTAGE	ABILITY TO REACH IDEAL WEIGHT	ABILITY TO TAKE ACTION
BELIEF IN ABILITY TO ACHIEVE GOALS	PERSONAL MAGNETISM	INCREASE LEARNING ABILITY
ABILITY TO RELAX	STRENGTHEN	BENEFICIAL, RELATIONSHIPS
ABILITY TO USE DREAMS AS MENTAL TOOL FOR PROBLEM SOLVING	MEMORY/CONCENTRATION	PROSPERITY (ATTRACT WHAT YOU CHOOSE)
ELIMINATE PROCRASTINATION	BREAKING OLD HABITS	ATTITUDE AND SKILLS AT WORK
	RELEASE NEGATIVE EVENTS	SELF-ESTEEM
	ABILITY TO ALIGN BODY/MIND FOR SELF-HEALING	YOUTHFUL VITALITY

BELOW, PLEASE DESCRIBE WHAT YOU WOULD LIKE TO ACCOMPLISH WITH THESE TREATMENTS:

CONSENT FORM

I, _____ (print name) consent to treatment for myself (or my minor child) _____ (print name), and understand that the services provided by Bagheera Bach, Inc. and John Mothershead are intended to enhance relaxation and increase communication within my body.

I understand that these services are not a substitute for medical treatment or medications. I am aware that diagnosis is not given and medication is not prescribed. I agree to continue to have regular medical check-ups as part of my overall health care plan.

I understand that participation is voluntary and that at all times I may choose to end my participation. I understand that I may experience 'healing reactions' during the 24 to 48 hours following the completion of services provided.

I understand that any information exchanged during any session is educational in nature and is to be used at my own discretion. I also understand that any information imparted during these sessions is strictly confidential in nature and will not be shared with anyone without my written permission. I do, however, give the practitioner consent to use my case history and results without using my name. I understand that only Bagheera Bach, Inc. and John Mothershead will have access to information in my file to enhance my healing.

I understand that by providing this informed consent I am assuming full responsibility for my services and I hold harmless the facility/ location where the services are provided, John Mothershead, and Bagheera Bach, Inc.

If candles are provided, I understand that I must burn them at my own risk and within sight. I will keep candles out of reach of children and pets. I will never burn my candle on or near anything that can catch fire. I will always burn my candle on a level heat-resistant surface.

I agree to the terms and conditions set out by this consent form and certify that the above information is true and correct. I agree to pay for distance sessions, should I request them.

_____ SIGNATURE

_____ WITNESS SIGNATURE

_____ DATE

_____ WITNESS PRINT NAME