# Client Consultation Form

## iUCT31 – Reiki

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|---|---|
| **Centre name:** | |
| **Centre number:** | |
| **Learner name:** | |
| **Learner number:** | |
| **Date:** | |

| | | |
|---|---|---|
| **Client name:** | | |
| **Address:** | | |
| **Profession:** | | |
| **Telephone number:** | Day: | |
| | Evening: | |

| **Personal details:** | | | | | | |
|---|---|---|---|---|---|---|
| Age group: | Under 20 ☐ | 20 – 30 ☐ | 30 – 40 ☐ | 40 – 50 ☐ | 50 – 60 ☐ | 60+ ☐ |
| Lifestyle: | Active ☐ | | | Sedentary ☐ | | |
| Last visit to the doctor: | | | | | | |
| GP Address: | | | | | | |
| Number of children: *(If applicable)* | | | | | | |
| Date of last period: *(If applicable)* | | | | | | |

| **Contra-indications requiring medical permission –** *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):* | | | | | |
|---|---|---|---|---|---|
| Any form of infection, disease or fever | ☐ | Pregnancy | ☐ | Cardiovascular conditions | ☐ |
| Under the influence of recreational drugs or alcohol | ☐ | Recent operations | ☐ | Any condition already being treated by GP or another complementary practitioner | ☐ |
| Cancer (unless in terminal stages and then with medical permission) | ☐ | Medical oedema | ☐ | Osteoporosis | ☐ |
| Arthritis | ☐ | Nervous/psychotic conditions | ☐ | Epilepsy | ☐ |
| Recent operations | ☐ | Trapped/pinched nerve | ☐ | Inflamed nerve | ☐ |
| Acute rheumatism | ☐ | Skin disease | ☐ | Undiagnosed lumps and bumps | ☐ |
| Cuts | ☐ | Bruises | ☐ | Abrasions (on exposed areas) | ☐ |
| Hypertension | ☐ | Hypotension | ☐ | Heart conditions | ☐ |
| Arthritis | ☐ | Diabetes | ☐ | Asthma | ☐ |
| Bell's palsy | ☐ | Inflamed nerve | ☐ | Fever | ☐ |
| Contagious or infectious diseases | ☐ | Recent fractures (minimum 3 months) | ☐ | | |
| **Understanding there are no known contra-indications to Reiki treatment when used on its own** | | | | | ☐ |

| **Written permission required by** *(either of which should be attached to the consultation form):* | |
|---|---|
| GP/specialist ☐ | Client disclaimer ☐ |

| **Personal information** *(Select if/where appropriate):* | | | | | | | |
|---|---|---|---|---|---|---|---|
| Muscular/Skeletal problems: | Back | ☐ | Aches/pain | ☐ | Stiff joints | ☐ | Headaches ☐ |
| Digestive problems: | Constipation | ☐ | Bloating | ☐ | Liver/gall bladder | ☐ | Stomach ☐ |
| Circulation: | Heart | ☐ | Blood pressure | ☐ | Fluid retention | ☐ | Tired legs ☐ |
| | Varicose veins | ☐ | Cellulite | ☐ | Kidney problems | ☐ | Cold hands and feet ☐ |
| Gynaecological: | Irregular periods | ☐ | P.M.T | ☐ | Menopause | ☐ | H.R.T ☐ |
| | Pill | ☐ | Coil | ☐ | Other: | | |
| Nervous system: | Migraine | ☐ | Tension | ☐ | Stress | ☐ | Depression ☐ |
| Immune system: | Prone to infections | ☐ | Sore throats | ☐ | Colds | ☐ | |
| | Sinuses | ☐ | | | Chest | ☐ | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Aggravates Sitting | ☐ | Standing | ☐ | Walking | ☐ | Running | ☐ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Regular antibiotic/ medication taken? | Yes | ☐ | No | ☐ | If yes, which ones? | | | |
| Herbal remedies taken? | Yes | ☐ | No | ☐ | If yes, which ones? | | | |
| Ability to relax: | Good | ☐ | Moderate | ☐ | Poor | ☐ | | |
| Sleep patterns: | Good | ☐ | Poor | ☐ | Average no. of hours: | | | |
| Do you see natural daylight in your workplace? | Yes | ☐ | No | ☐ | | | | |
| Do you work at a computer? | Yes | ☐ | No | ☐ | If yes, how many hours? | | | |
| Do you eat regular meals? | Yes | ☐ | No | ☐ | | | | |
| Do you eat in a hurry? | Yes | ☐ | No | ☐ | | | | |
| Do you take any food/vitamin supplements? | Yes | ☐ | No | ☐ | If so, which ones? | | | |
| How many portions of each of these items does your diet contain per day? | Fresh fruit: | | Fresh vegetables: | | Protein and source: | | | |
| | Dairy produce: | | Sweet things: | | Added salt: | | Added sugar: | |
| How many units of these drinks do you consume per day? | Tea: | | Coffee: | | Fruit juice: | | Water: | |
| | Soft drinks: | | Others: | | | | | |
| Do you suffer from food allergies? | Yes | ☐ | No | ☐ | | | | |
| Bingeing? | Yes | ☐ | No | ☐ | | | | |
| Overeating? | Yes | ☐ | No | ☐ | | | | |
| Do you smoke? | Yes | ☐ | No | ☐ | How many a day? | | | |
| | Other: | | | | | | | |
| Do you drink alcohol? | Yes | ☐ | No | ☐ | How many units a day? | | | |
| Do you exercise? | None | ☐ | Occasional | ☐ | Irregular | ☐ | Regular | ☐ |
| | Types: | | | | | | | |
| What is your skin type? | Dry | ☐ | Oily | ☐ | Combination | ☐ | Sensitive | ☐ | Dehydrated | ☐ |

| | | | | |
|---|---|---|---|---|
| Do you suffer/have you suffered from | Dermatitis ☐ | Acne ☐ | Eczema ☐ | Psoriasis ☐ |
| | Allergies ☐ | Hay fever ☐ | Asthma ☐ | Skin cancer ☐ |
| Stress level 1–10 (10 being the highest): | At work ☐ | | At home ☐ | |

| **Reason for treatment:** |
|---|
| |

| **A client profile must be included in the case study** | |
|---|---|
| Client profile: | |
| Your Reiki lineage: | |
| Details of how the therapist conducted the treatment: | |
| Details of how the client felt during and after the treatment: | |

| | |
|---|---|
| | |
| Details of home care advice given: | |
| Overall conclusion of each case study including reflective practice: | |

**ONE WRITTEN MEDITATION TO BE INCLUDED AS A SAMPLE.**

**ONE STUDY MUST BE DISTANT OR ABSENT REIKI.**

**Learner signature**: _____

**Client signature**: _____

## **iUCT31 –** Follow-up sheet

| **A client profile must be included in the case study** | |
|---|---|
| Client profile: | |
| Your Reiki lineage: | |
| Details of how the therapist conducted the treatment: | |
| Details of how the client felt during and after the treatment: | |
| Details of home care advice given: | |
| Overall conclusion of each case study including reflective practice: | |

**ONE WRITTEN MEDITATION TO BE INCLUDED AS A SAMPLE.**

**ONE STUDY MUST BE DISTANT OR ABSENT REIKI.**

**Learner signature**: _____

**Client signature**: _____

## **iUCT31 –** Personal development log/CPD – to be associated with case studies

| **Should include:** | |
|---|---|
| Shares/groups attended: | |
| Dates: | |
| Reiki/healing circles or workshops: | |
| Show knowledge of other forms of Reiki e.g. Terra Mai, Seichem: | |
| Reading, video, audiotapes: | |
| Websites, research organisations involved: | |
| Selected events: | |
| Dates: | |

| | |
|---|---|
| Must show evidence of 21 days personal healing on self (with results) at each degree including master symbols: | |

**Learner signature**: _____

**Client signature**: _____