|  |
| --- |
| PERSONAL INFORMATIONLast Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth (dd/mm/yy):\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_  /\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| EMERGENCY CONTACT Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Link: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| INFORMATION 1. Have you ever received a therapeutic or energy care? ……..………………………..……..

If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Are you undergoing other therapeutic care? ……….…………………………………………….

If so, what care and frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Do you have health insurance? ……………………………………………………………….…………

If so, do you want a receipt in naturopathy? \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Do you have a family doctor? ……………………………………………………………….…………..

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Are you particularly sensitive to touch? ……………………………………………………………

If so, do you have a particular health condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Have you been referred by someone? ..................................................................

If so, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Yes
* Yes
* Yes
* Yes
* Yes
* Yes

  | * No

 * No
* No
* No
* No
* No
 |
| 1. What activities or leisure do you practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| AUTORISATION1. I would like to receive occasional information about the services via e-mail?
2. Are you a minor age less than 18 years. If so, add the name of the adult present and signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Yes
* Yes
 | * No
* No
 |
| RESERVED FOR THE PRACTITIONNERName : Caroline Paré Number of visits : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| HEALTH INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| **Conditions – please check if it is CURRENTLY a concern or if it has affected you IN THE PAST.** | Currently | In the past | Precisions: |
| Accident |  |  |  |
| Allergies |  |  |  |
| Cancer |  |  |  |
| Cardiovascular disease |  |  |  |
| Circulatory disorders |  |  |  |
| Digestive disorders |  |  |  |
| Emotional or mental disorders |  |  |  |
| Hearing disorders |  |  |  |
| Eating disorders |  |  |  |
| HIV/ Aids |  |  |  |
| Muskuloskeletal disorders |  |  |  |
| Neurological or brain disorders |  |  |  |
| Pregnancy |  |  |  |
| Respiratory or pulmonary disorders |  |  |  |
| Skin disorders |  |  |  |
| Sleep disorders |  |  |  |
| Surgeries |  |  |  |
| Vision disorders |  |  |  |
| Others |  |  |  |
| Medication (1) |  |  | Reason: |
| Médication (2) |  |  | Reason: |

 |
| UNDERSTANDING – Please initial each of the following statements: \_\_\_\_\_ …I understand that Reiki is a gentle, energetic and hands-on approach;\_\_\_\_\_ …I understand that the practitioner does not diagnose conditions nor prescribe or perform medical treatment;\_\_\_\_\_ …I understand that energy work does not replace medical care and care offered by other health professional;\_\_\_\_\_ … I understand that medication, dosage is entirely under the responsibility of your doctor;\_\_\_\_\_ …I understand that I am responsible for pursuing necessary care with a doctor and/or psychologist as needed;\_\_\_\_\_ … I understand that I am receiving this treatment out of my own choice;\_\_\_\_\_ …I understand that through hypnosis and relaxation the body may improve in certain aspects; \_\_\_\_\_ …I understand that under hypnosis I continue to be conscious of my choices and free will;\_\_\_\_\_ … I understand the practionner has a right to refuse to treat a client;\_\_\_\_\_ …I understand this approach may require several sessions; Appointments must be cancelled 48 hours in advance;\_\_\_\_\_ …I understand this treatment is a service for which I will pay the due amount.Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |