Health Overview

Print Name: _____ Date: _____

Please "X" all items below that apply and give descriptions where requested.

↓	**HEALTH CONDITION**	DESCRIPTION / ADDITIONAL INFORMATION
	A.D.D / A.D.H.D.	
	Adrenal Exhaustion or Chronic Fatigue	
	Anemia	
	Aneurism or at risk for aneurism	
	Angina	
	Anxiety ☐ More Recent *OR* ☐ Life-Long	
	Arthritis ☐ Osteo ☐ Rheumatoid	
	Asthma	
	Autoimmune Disease *Describe* →	
	Bi-Polar Disorder	
	Blood Pressure – HIGH, under control	
	Blood Pressure - LOW	
	Cancer ☐ In treatment now ☐ Post treatment →	Type of Cancer: Year of Diagnosis:
	Carpal Tunnel	
	Carotid Artery Disease	
	Chronic Pain • *Average pain level is* _____ • *Area(s) of pain are* _____	*Movements that aggravate pain:* *Movements that seem to help pain:*
	COPD	
	Depression ☐ More Recent *OR* ☐ Life-Long	
	Diabetes, under control	
	Digestive Issues	
	Dizziness / Vertigo	
	Glaucoma	
	Heart Disease	

	Headaches – Migraines	
	Hearing Problems	
	Hiatal Hernia	
	History or Physical, Emotional or Sexual Abuse	
	History of ☐Congestive Heart Failure or ☐Stroke	
	IBD ☐ Constipation ☐ Diarrhea	
	Insomnia ☐ More recent *OR* ☐ Long-term	
	Joint Replacement(s)	***Information Noted on #3 New Client Form***
	Lymphedema *Please describe area(s) affected →*	
	Narcolepsy	
	Neuropathy	
	Neurological Disorder *Please note type →*	
	☐ Osteoporosis Or ☐ Osteopenia	
	Pacemaker *OR* Other Implanted Medical Device	***Information Noted on #4 New Client Form***
	Post-Traumatic Stress Disorder (PSTD)	
	Reproductive System Issues (such as POCS)	
	Scoliosis ☐ C Curve ☐ S Curve **OR** ☐ Kyphosis	
	Thyroid Condition ☐ Hyper ☐ Hypo	
	Viral Disease ☐ AIDS / HIV ☐ Polio ☐ Herpes ☐ Meningitis ☐ Hepatitis	
	Other Health Issue:	

1. What is your current level of stress? ☐ Low ☐ Medium ☐ High ☐ Very High
2. What tends to trigger stress for you? _____
3. How has your overall energy level been lately? ☐ Low ☐ Good ☐ Too Busy/High
4. Do you have any prior experience with Reiki Therapy? ☐ No ☐ Yes
5. Do you have any prior experience with yoga? ☐ No ☐ Yes
6. Do you have any movement limitations or movements that cause you discomfort or that are difficult for you? ☐ No ☐ Yes → If yes, please describe below: