Adrienne Beaupré & Assoc. LLC
65 Central St. Suite 5, West Boylston, MA 01583
508-869-4755

New Client History

Date:_____

First Name:	Last Name:	Birth Date:
Street Address:	City:	State: Zip Code:
Home phone #:	Cell#:	Work#:
Email:		**Please circle best method(s) to reach you regarding appointments.**

Occupation:	**Referred by:**
Primary Care Physician:	Other Providers of Care:
Date of Last Physical:	

Please list any medications prescription and over the counter you are currently taking:_____

_____

_____

Please list any supplements that you are currently taking: _____

_____

_____

Allergies (environmental/lotions/oils/foods): _____

_____

Please circle Past or Current experience of complimentary therapies: Nutritional Herbal Massage/Body Work Acupuncture Chiropractic Physical Therapy Energetic Counseling Other:

What is the primary reason for your visit today? _____

_____

_____

When did you first notice this? _____

What brought it on? _____

Describe andy stressors at the time: _____

Does anything provide relief? _____

What makes it worse? _____

Is this condition getting: Better Worse No Change

Is this condition interfering with: Work Sleep Recreation

Previous treatments for this complaint:_____

_____

Other reasons for your visit you or symptoms you are experiencing: _____

_____

_____

List any major illnesses (with approx. dates):_____

_____

List any surgery or operations with approx. date:_____

_____

Past Accidents or injuries:_____

_____

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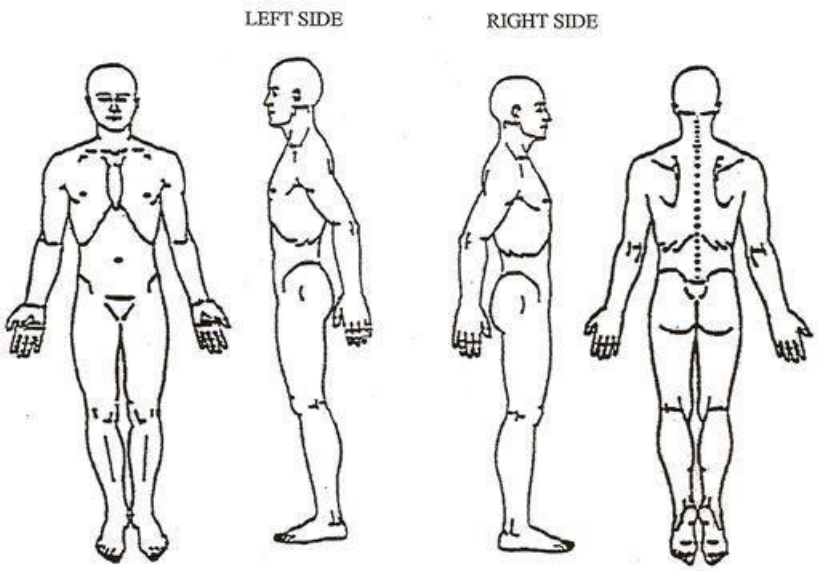
Please mark on the drawings below where your pain is and where you hold your tension.



Circle any of the following conditions you have experienced. Indicate past or present

Anemia
Arthritis, area:
Asthma
Athlete's foot
Autoimmune, type:
Bleeding
Blood Clots
Bruising
Blood Pressure Issues
Bursitis
Cancer
Cardiac
Circulatory:
Cold Hands/Feets/Swelling
Cold Sweats
Diabetes
Digestive Problems
Dizziness/Fainting
Endocrine
Hepatitis
Hernia
Joint Problems
Kidney/Urinary Issues
Liver/Gallbladder
Low Back Pain
Muscle Sprain/Strain
Numbness
Osteoporosis
Pins (orthopedic)
Pacemaker
Pins
Respiratory
Sciatica/Nerve Pain
Seizures
Sinus problems
Skin conditions
Sore heels when walking
Ulcers
Varicose Veins
Vertebral/Intervertebral disc problems
Other:_____

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Is it possible that you are currently pregnant: Yes/No

If pregnant , What is your estimated due date:_____

Is this pregnancy considered high risk: Yes/No

If high risk please explain:_____

Lifestyle, Emotional & Spiritual

What hobbies/activities provide you with pleasure and accomplishment? _____

_____

What are your exercise habits/frequency?:_____

Overall health (circleone): Excellent / Good/Fair / Poor / Other:_____

Circle any of the following conditions that you have experienced. Indicate past/present:

Anxiety

Depression

Insomnia/Sleep Disturbance

Stress Recent Loss:

Other:

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other

_____

Any household pets or other animals you or family members are in close contact with:

_____

What do you expect from your treatment here:_____

What can we do to make you happier: _____

What changes would you like to achieve in 6 months: _____

One Year:_____

Additional information that would be important for your practitioner to know:

Signature:_____ **Date:_____**

Office Use Only:

Oil	
Lotion	
Essentials	
Likes:	**Dislikes:**

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Reiki Consent

I_____have received information and understand that Reiki is a gentle, complementary energy based approach to health and healing that can assist my body in its natural ability to heal. I fully acknowledge and understand that this is accomplished through the use of contact and/or noncontact touch.

It has been explained to me, that Reiki is a complementary therapy not intended to replace any currently prescribed medical treatments as ordered by my physicians nor any other medical care I have I may be advised to seek by them.

I have been informed that my Reiki practitioner will neither diagnose any medical condition nor prescribe for any condition that I might have nor does she make any specific claims regarding results from the Healing Touch sessions that I receive.

I have been encouraged to consult a licensed medical practitioner for any physical or mental complaints I may have.

Some of the indications for a Healing Touch session include, but are not limited to:

- Reduction in pain, anxiety and stress
- Decrease in nausea
- Preparation for medical treatment and procedures and to manage side-effects
- Support during chemotherapy
- Supports the body's natural healing process and sense of well-being
- Facilitation of wound healing
- Emotional-Mental-Spiritual support

I have been informed that all client information and records are treated in a confidential manner. My experiences during these sessions are confidential subject to the usual exceptions governed by State or federal laws and regulations.

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless my Reiki practitioner and Adrienne Beaupré & Assoc. LLC from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

My questions have been answered to my satisfaction regarding my Reiki practitioner's background, Reiki, and what I might expect from this session.

I give my consent to receive Reiki.

Signed _____ Date: _____

Print Name: _____

Parent/Legal Guardian for:_____

Our Policies:

This is a chemical fragrance-free space. A comfortable and non-toxic environment is our goal. We choose our products carefully. Thank you for not wearing any of the following during your visit: cologne, after shave, perfume, perfumed hand lotion, and fragranced products.

Our chemically-sensitive co-workers and clients thank you.

Cancellations/Missed Appointments: We require a minimum of 24hrs notice for all cancellations to avoid full service charge. Your appointment is important to us.

Signed:_____ Date:_____