Client Name: _____

Phone: _____

Complete Client Profile and Consent Forms

Gentle Illumination

Le Joy Rothe

2010 East Hennepin Ave

Building One

Minneapolis, MN 55413

(612) 788-8997 (h)

(612) 643-3517 (b)

lejoyrothe@comcast.net

www.gentleillumination.com

Informed Consent in Health Care Decisions

Name (please print _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: ( ) _____

Referred by: Name _____ **Website** _____ **Paper** _____

I confirm that I am of legal age (18 or older) and I am requesting a consultation with Le Joy Rothe, Reiki Master and Certified Aromatherapist. In consideration of my acceptance as a participant in this private consultation session, I for myself, heirs, executors, administrators and assignees, or any other relation, do herby release and discharge _____ or any other employees from all claims of damages, demands, or actions whatsoever in any manor arising from or growing out of my participation.

To the best of my knowledge, I have given Le Joy Rothe the truth in all dealings and understand that my own information is the source of recommendations, services and custom blend (or otherwise) products purchased or used in turn. I wholeheartedly understand that following any set regime does not promise any form or level of cure for any specific (or otherwise) condition. I promise to abide by any warnings or contra-indications given to me through consultation if products and services are used. I understand that I am under no obligation to follow any recommendations for treatment given by Le Joy Rothe. I understand Natural Health is not an absolute science.

Client Signature: _____

Parent or Guardian Signature (if a minor): _____

Le Joy Rothe, Aromatherapist _____

Date: _____

Client Bill Of Rights

"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS."

Any complaints or concerns may be filed with:
Office of Complementary and Alternative Health Care Practice
Health Occupations Program
Suite 400, Metro Square
P.O. Box 64975
St. Paul, MN 55164-0975
651-282-6344

Fees:
Reiki: $60.00 per hour long session (unless a sale is occurring), paid at the end of each session. Sessions range from 30 minutes ($45) up to 1 1/2 hours ($80). I offer FREE Reiki distance healing sessions. Aromatherapy: Initial consultation is FREE, unless products are purchased. Products: various pricing applies individually per blend.

Cancellation Policy: I would appreciate at least 3 hours or more notice for cancellation, however I respectfully request 24 hours notice if at all possible. Call either (612) 788-8997 or (612) 643-3517.

Reiki and Aromatherapy:
Reiki is a stress reduction and relaxation technique that promotes healing on all levels and when practiced as a hands-on (as well as off-the-body in person or over a distance) method it is always gentle, gentle-touch and relaxing. Aromatherapy (simply put, the use of plant extracts in a way that promotes the body/mind/spirit to heal) and Reiki sessions are for the purpose of helping clients deeply relax, to help facilitate our own natural healing processes, to relieve stress and to connect with your own spirituality. Spirituality can be described in many ways such as prayer, how you make your choices and decisions in life and how you respect yourself and others.

Long term imbalances in the body can require multiple sessions/appointments and some small trial and/or error of products to allow the body to bring the system back into balance. Even self imposed self-improvement requires commitment on the part of the client, and the client must be willing to change in a positive way to receive the full benefit of any form of traditional or alternative forms of medical treatment.

I do not diagnose conditions, nor interfere with the treatment of any licensed medical professional. If you are not seeing a licensed medical professional for treatment and I feel medical attention is paramount, I will make a referral for you to do so. Depending on the issue, Reiki and Aromatherapy are meant to be used in conjunction with any treatment that you and your doctor have decided upon.

It is a client's right:
- To know at any time why any process is being taken.
- To courteous treatment free from any verbal, physical, or sexual abuse.
- To know the estimated duration of treatment.
- To view or make copies of his/her file.
- To refuse treatment at his/her determination.

I ACKNOWLEDGE ALL INFORMATION ABOVE AND UNDERSTAND THAT I MAY ASSERT ANY OF THESE CLIENTS' RIGHTS WITHOUT RETALIATION. I AM AWARE THAT ALL CONVERSATIONS AND TRANSACTIONS BETWEEN MYSELF AND MY PRACTITIONER ARE CONFIDENTIAL AND SHALL NOT BE DISCLOSED EXCEPT BY THE CLIENT'S WRITTEN AUTHORIZATION OR AS OTHERWISE PRESCRIBED BY THE LAWS OF THE STATE OF MINNESOTA (INITIAL) _____. I HAVE RECEIVED THE CLIENT BILL OF RIGHTS AND UNDERSTAND WHAT I HAVE JUST READ. _____

Signature: _____ *Date:* _____

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Signature: _____ *Date:* _____

For Office Use Only: Dates of Service _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Client Dietary Information and Daily Condition

General Questionnaire:	Date:
Name:	Sex: M _____ F _____
Address:	Phone:
Date of Birth: / /	Occupation:
Height:	
Weight:	
First name of (circle) Spouse/Other/Parent: Single	Children: How many and ages?
Referred by:	
Reason for coming:	

Types of food eaten. Indicate frequency of food eaten by writing **S** (seldom), **M** (moderate) or **H** (heavy).

Meat	Wheat bread	Sugar
Poultry	Cooked Vegetables	Sweet foods
Fish	Raw Vegetables	Salty foods
Eggs	Fresh fruit	Fried foods
Cheese	Beans	Water
Milk	Potatoes	Caffeinated Beverages
Other dairy products	Malt	Coffee
White bread	Chocolate	Tea

Do you smoke and if so how long?
List drugs (recreational and otherwise) used currently and in the past
List Vitamins used currently and in the past:
Do you exercise regularly? Yes_____No _____

Client Dietary Information and Daily Condition– continued:

Bowels (how often do they move per day?):
Menstruation (pain, heavy or light, menopause):
Contraception of choice:
Reason for visit: frequency of pain (seldom, often, always?):
Level of pain on a scale of 1—10:
Does pain interfere with (circle all that apply): work Sleep Daily routine Exercise
Headaches (do you have them and if so how often?):
Operations and major accidents:
Family history of illness:
Further comments for consideration:
For Office Use Only - Do not write below this line
Blood pressure:
Temperature:
Pulse:
Outward observations:

Signature _____ *Date:* _____

Health Information

Name:_____

Are you currently undertaking any medical/therapeutic treatment? _____ Yes _____ No If yes, explain:

_____

_____

_____

If yes, list the Doctors name and phone _____

Do you give permission to consult above person? _____ Yes _____ No (Please initial) _____

List any medications (including prescription and over-the-counter) and vitamin supplements you are taking:

_____

_____

Any known allergies? _____ Yes _____ No If Yes, what are they? _____

_____

List anything (surgeries, treatments, etc...) from health history that would pertain to your current condition

_____

_____

When did you first notice symptoms/complaints _____

Are symptoms getting worse? _____

Is there anything you are able to do to get relief from pain? If so, what? _____

_____

_____

Explain what your long-term goals (health or otherwise) are for this association: _____

_____

_____

Signature _____ *Date:* _____

Client Case Study and Treatment Plan

Name:_____ Date: _____

Assessment: _____

_____

_____

_____

My Goals for Client: _____

_____

_____

Client Preferences: _____

_____

Treatment Plan: _____

_____

_____

_____

Notes: _____

_____

_____

PractitionerSignature _____ Date: _____

Client Signature _____ Date: _____

Oils and Custom Blend Formulas Used

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