

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 hereby 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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Date: \_\_\_\_\_

For Office Use Only: Dates of Service \_\_\_\_\_



## 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:

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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:

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Any known allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, what are they? \_\_\_\_\_

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

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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? \_\_\_\_\_

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

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Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Client Case Study and Treatment Plan

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Assessment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

My Goals for Client: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client Preferences: \_\_\_\_\_

\_\_\_\_\_

Treatment Plan: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

