Holistic Wellness Center New Client Intake Form

Name: ________________________________-________________________________ DOB: ___________________________________

Phone: _______________________ Carrier (for apt. reminders): ___________________ E-mail: ___________________________________

Address: _____________________________________ City: ____________________ State: _______________ Zip: __________________

Occupation: __________________________________ Physician: ________________________ Gender: ___________________________

Emergency Contact: ________________________________ Relation to Client: _____________ Phone: ____________________________

Referred By: ____ Phone: ____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional bodywork or energy session? ☐ Yes ☐ No How recently? __________________________________

What are your bodywork or energy work goals? ____

What kind of pressure do you prefer? ☐ light ☐ medium ☐ firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

☐ Yes ☐ No Do you frequently suffer from stress?

☐ Yes ☐ No Do you have diabetes?

☐ Yes ☐ No Are you insulin dependent? Last dose: __________

☐ Yes ☐ No Do you experience frequent headaches?

☐ Yes ☐ No Are you wearing contact lenses?

☐ Yes ☐ No Are you wearing dentures?

☐ Yes ☐ No Do you have high blood pressure?

☐ Yes ☐ No Are you taking high blood pressure medication?

☐ Yes ☐ No Do you suffer from epilepsy or seizures?

☐ Yes ☐ No Do you suffer from joint swelling?

☐ Yes ☐ No Do you have varicose veins?

☐ Yes ☐ No Do you have any contagious diseases?

☐ Yes ☐ No Do you have osteoporosis?

☐ Yes ☐ No Do you have cancer?

☐ Yes ☐ No Other medical condition, or are you taking any medications I should know about?

☐ Yes ☐ No Do you bruise easily?

☐ Yes ☐ No Any broken bones in the past two years?

☐ Yes ☐ No Any injuries in the past two years?

☐ Yes ☐ No Do you have any tension or soreness in a specific area? Please specify: ______________ ______________________________________

☐ Yes ☐ No Do you have cardiac or circulatory problems?

☐ Yes ☐ No Do you suffer from back pain?

☐ Yes ☐ No Do you have numbness or stabbing pain?

☐ Yes ☐ No Are you sensitive to touch or pressure in any area? Please specify: ___________________

☐ Yes ☐ No Have you ever had surgery? Explain below.

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Do you suffer from lymphedema?

☐ Yes ☐ No Do you have any allergies?

Comments: ____
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I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of this session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances by me will result in immediate termination of the session, and I will be liable for any payment of the scheduled appointment.

Client Signature: ____ Date: ____________________________

Consent to Treatment of Minor: By my signature below, I hereby authorize __________________________________ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent of Guardian: ____ Date: ______________________