Holistic Restoration Client Intake Form

Name _____ DOB _____/_____/_____ Date _____
Address _____ City _____ State____ Zip _____
Phone (H) _____ (W) _____ (C) _____
SS# _____ Email Address _____
Employer _____Occupation _____
Daily duties (standing, sitting, telephone, computer, etc…) _____
_____
Referred by _____
Emergency Contact _____ Relationship _____ Phone _____
Have you had massage before? _____ If so, what kind of massage? _____

Please list any injuries obtained within the past 72 hours _____
_____
_____
Past surgeries with dates: _____
_____
Please list any medications (including over-the-counter, vitamins/supplements) and what they are for:
_____
_____
_____

Are you currently experiencing any of the following conditions? (Yes/No)
___ Flu or cold ___ Inflammation ___ Fever ___ Infections ___Contagious disease

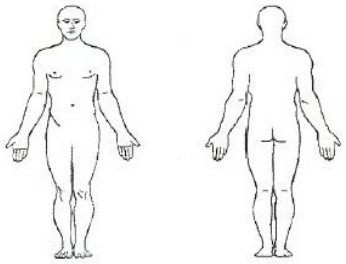
Chief complaint: _____
_____

Check all that apply (current, past or re-occurring conditions included)

___ bruise easily
___ **diabetes**
___ **high blood pressure**
___ sinus/allergies
___ **pregnant** (# of wks ___)
___ shoulder pain
___ knee pain
___ joint pain/swelling
___ spasms/cramps
___ dizziness/vertigo
___ **seizure disorders**
___ **blood clots/phlebitis**
___ psoriasis
___ sciatica
___ low blood pressure
___ jaw clenching/grinding
___ carpal tunnel syndrome
___ exercise
___ headaches
___ stress
___ neck pain
___ arm pain/numbness
___ radiating pain
___ fibromyalgia/CFS
___ osteoporosis
___ **cancer**
___ **hypertension**
___ premenstrual syndrome
___ warts/moles
___ tendonitis
___ varicose veins
___ circulation problems
___ contact lenses
___ **heart condition**
___ migraines
___ TMJ dysfunction
___ upper/middle/low back pain
___ leg/hip pain/numbness
___ arthritis
___ sprains/strains
___ asthma/respiratory issues
___ insomnia
___ constipation/digestion problems
___ athlete's foot
___ rashes
___ bursitis
___ **stroke**
___ anxiety/depression
___ other: _____

Please indicate any areas of pain, tension or discomfort by marking the illustrations.

Rate your pain/tension/discomfort on a scale of 1 to 10, with 10 being most severe _____



Of the conditions indicated about, which is your **highest** priority to address? _____

Office Policies

My initials indicate that I have read & agree to adhere to the office policies throughout my care.

___ If referred by another health care provider, I give permission to update the referring individual on my progress.

___ If I arrive past my scheduled appointment time, I am still responsible for the entire session fee.

___ I understand that I am liable for the full session fee of any appointment cancelled with-in 24-hours of the scheduled time.

___ I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will automatically end the session and I will be liable for the scheduled session fee.

___ I understand that either the therapist or myself have the right to terminate the session at any time.

Informed consent: Please take a moment to carefully read the following & sign where indicated.

I understand that the information above is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain or discomfort during the session so the pressure and/or strokes may be adjusted to my level of comfort. I understand that massage therapists do not diagnose conditions, prescribe medications or manipulate bones. I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so.

Signature _____ Date _____

Consent to treat a minor: My signature authorizes _____ to perform massage and bodywork therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian _____ Date _____

Therapist's Signature _____Date _____