Healing Solutions Inc

RELIEVING PAIN. RESTORING LIVES.

Confidential Client Intake & Health History Form

NAME _____

BIRTH DATE _____ AGE _____ ☐ MALE ☐ FEMALE

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL # _____
Is it appropriate to contact you regarding your massage at the number listed above? ☐ Yes ☐ No
Do I have your permissions to send you text messages? ☐ Yes ☐ No

E- MAIL ADDRESS _____
(Providing an e-mail address indicates that it is ok to send you newsletters, promotions and specials from Healing Solutions Inc.)

OCCUPATION _____ EMPLOYER _____

REFERRED BY _____

MARITAL STATUS _____ SPOUSE'S NAME (if applicable) _____

In case of an emergency contact: _____ Phone # _____

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First professional Massage: ☐ Yes ☐ No; how frequently do you have massage: _____

Do you have any difficulty lying flat? ☐ Yes ☐ No

Do you have any **allergies** to medicine essential oils and/or skin products? ☐ No ☐ Yes, please specify _____
_____

Are you taking medication? ☐ No ☐ Yes, please list _____
_____
_____

List accidents/ injuries, hospitalizations, and surgeries in the past 10 years: when they occurred and treatment received:
_____
_____
_____

Any lingering effects from the above? ☐ No ☐ Yes, please explain _____
_____
_____

Chronic, ongoing pain? ☐ No ☐ Yes, please describe pain and any care or treatment you receive: _____
_____
_____

Are you receiving any other type of medical treatment? ☐ No ☐ Yes, please explain _____

_____

Medical Doctor's Name _____ Phone # _____

Chiropractic Doctor's Name _____ Phone # _____

What are the main sources of stress in your life?

_____

_____

Where in your body do you feel the effects of stress?

_____

_____

Please list all forms of self-care/ stress-reduction?

_____

_____

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History: please check all that apply (Last 5 Years)

Musculoskeletal

☐ Broken bones in the last 2 years
Where? _____
☐ Bruise Easily
☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Chronic Fatigue
☐ Chronic Headaches
☐ **Chronic** pain in:
- ☐ Neck
- ☐ Low- back
- ☐ Mid-back
- ☐ Upper-back
- ☐ Hip
- ☐ Arm
- ☐ Leg
- ☐ Shoulder
- ☐ Wrist/ Hand

☐Whiplash
☐ Cysts/ Lipomas; where? _____
☐ Decreased range of motion; where?
_____
☐ Fibromyalgia
☐ Gout in _____

☐ Hypothyroidism
☐ Joint Ache; where? _____
☐ Osteoporosis
☐ Plantar Fascitis
☐ Sciatica
☐ Scoliosis
☐ Spasms/ Cramps; where? _____
_____
☐ Sprains/ Strains; where? _____
_____
☐ Stabbing Pain; where? _____
☐ Tendonitis; where? _____
☐ Thoracic Outlet Syndrome
☐ TMJ
☐ Rheumatoid Arthritis/ Osteoarthritis
Where? _____

Respiratory

☐ Asthma
☐ Bronchitis
☐ Cough
☐ Pneumonia
☐ Shortness of Breath
☐ Sinusitis

Circulatory

☐ Anemia
☐ Blood Clots/ Phlebitis; where? _____
☐ Diabetes
☐ Heart Attack; when? _____
☐ Heart Problems; type? _____
_____
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Mirtal valve prolapse
☐ Palpitations
☐ Peripheral Artery Disease
☐ Stroke
☐ Varicose Veins; where? _____

Digestive

☐ Abdominal Pain
☐ Acid Reflux

☐ Chronic Indigestion
☐ Colitis
☐ Constipation
☐ Crone's Disease
☐ Diarrhea
☐ Gallstones
☐ Gas/ Bloating
☐ Ulcers

Skin

☐ Athlete's Foot
☐ Eczema/Dermatitis
☐ Fungal Infection
☐ Impetigo
☐ Psoriasis
☐ Skin easily irritated
☐ Warts

Nervous System

☐ Bell's Palsy
☐ Dizziness
☐ Multiple Sclerosis
☐ Neuritis
☐ Numbness/ tingling; where? _____
☐ Seizures/ Epilepsy
☐ Spinal Cord Injury; where? _____

Other

☐ Allergies affecting:
- ☐ Body Skin
- ☐ Eyes
- ☐ Facial Skin
- ☐ Nose/ Sinuses
- ☐ Stomach

☐ Cancer where? _____
☐ Cystitis

☐ Emotional Concerns
- ☐ Anxiety/ Panic Attacks
- ☐ Bipolar Syndrome
- ☐ Depression
- ☐ Grieving
- ☐ High Stress

☐ Hepatitis
☐ HIV/ AIDS
☐ Kidney Disease
☐ Lupus
☐ Mastectomy
☐ Orthopedic pins/ plates where? _____
☐ PMS/ Menopause difficulties
☐ Poor sleep/ Insomnia
☐ Postoperative: _____
☐ **Pregnancy, which trimester?** _____
☐ Wear Contacts
☐ Other: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____

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Do you have any of the following today?

☐ N/A
☐ Inflammation
☐ Severe pain
☐Open cuts, bruises, burns
☐ Irritated skin rash
☐ Infection
☐ Headache
☐ Cold/ flu
☐ Fever
☐ Contagious disease
☐ Alcohol intake in the last 24 hours
☐ Sunburn

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What is your daily water intake? ☐ Mild ☐ Moderate ☐ Heavy (Desirable daily water intake is ½ your body weight in ounces)

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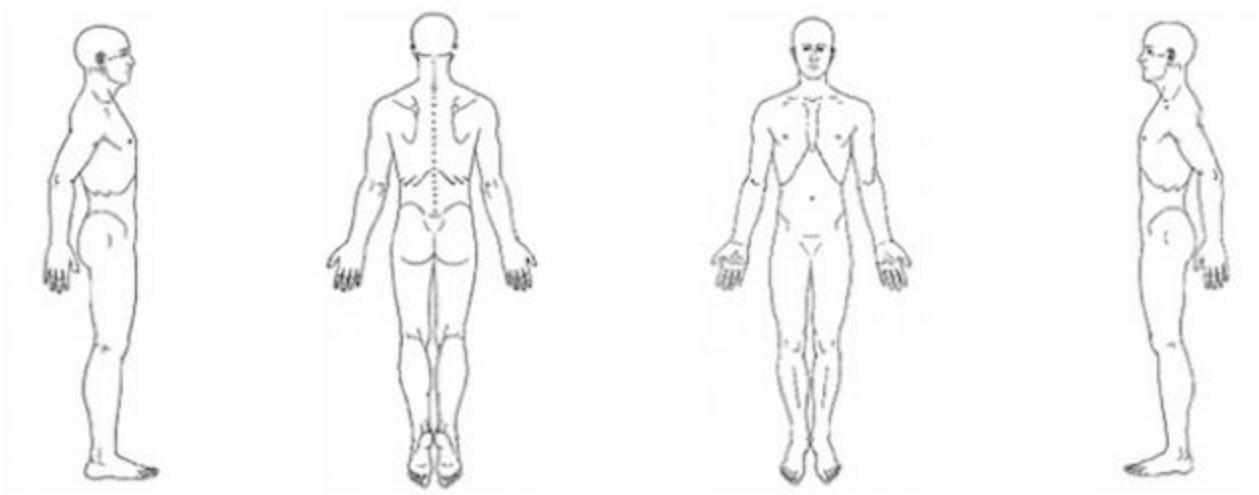
Please circle any areas of pain/ tension you would like to focus on:



What are you hoping to accomplish in today's session?

_____

_____

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Release of Liability

1. The above information is accurate. I understand the Massage Therapist is providing bodywork that is within their scope of practice. I hereby consent for my therapist to treat me with massage therapy, energy work, cupping aromatherapy, and yoga for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my massage therapist. I understand that massage therapy and integrative bodywork therapies are provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow. I acknowledge that the therapist is not a physician and does not diagnose disease or prescribe drugs and that they are not a substitute for medical care.
   I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. I agree to alert my practitioner immediately of any physical/emotional changes as they occur so treatment can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain I experience during or after a session.
   I have completed the intake form as provided by Healing Solutions Inc and disclosed to my therapist all of my known medical conditions that may impact my ability to be a client. It is my responsibility to keep the massage therapist updated on changes in my health and medical conditions. I understand that there shall be no liability on the therapists part should I forget to do so. I have read the above noted consent and I have had the opportunity to question the contents and my therapy. I confirm my consent to treatment and intend this consent to cover all of my treatments at Healing Solutions Inc. I hereby waive and release Suzette Skidmore, Rachel Farmer, and Healing Solutions Inc form any and all liability past, present, and future relating to massage therapy and all forms of integrative bodywork.

Communication

2. I (the client) understand that massage/ bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during a session, I will ***immediately*** inform

the practitioner so that pressure or strokes may be adjusted to my level of comfort. I understand that giving feedback to my practitioner helps to create a treatment that works best for me. Any changes I need will be communicated to the practitioner. (i.e. too cold, too hot, want different music, pressure is too light)

Medical Background

3. I understand if I have a specific medical condition or specific symptoms, massage/ bodywork may be contraindicated. A referral from my primary care provider may be required prior to service being provided. 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 a session should be construed as such.
   I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioners part should I fail to do so. I take responsibility for alerting my practitioner of any physical, mental or emotional changes that occur with my health.

Inappropriate Behavior

4. I (the client) understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the scheduled appointment.

Confidentiality

5. I understand all information disclosed will be kept confidential.

Therapeutic Grade Essential Oils

6. I understand my responses to therapeutic grade oils are based upon my unique body chemistry. Although allergic reaction to therapeutic grade essential oils are rare, I will contact my physician should any allergic reaction become a concern to me.

Scheduling and Cancellations

7. I understand that I need to be on time for an appointment. If I am late, the session will be shorter, allowing the practitioner to finish on schedule. I agree to provide 24 hours notice if I need to cancel an appointment or reschedule. I understand that Healing Solutions Inc has a 24-hour cancellation policy. I agree to pay any fees, subject to change, associated with late cancellation, lack of notification or for missed appointments per the cancellation policy. See cancellation policy for specific guidelines (pg 4.).

Payment

8. Methods of payment accepted by Healing Solutions Inc. are Visa, MasterCard, check, or cash. Any returned check will be assessed a return check fee of $ 25.00.

Privacy Policy

9. I have read the privacy policy for Healing Solutions Inc and understand and agree to the terms.

Signature _____ Date_____

Healing Solutions Inc

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Appointment/ Cancellation Policy

Healing Solutions Inc. strives to offer you the best service possible. In order to do so we invest time and money in continuing education, and certifications to provide you with the most up to date interventions. A major component to reaching your health and wellness goals is accountability and adhering to your scheduled appointment time. We require a 24 hour notice if you need to cancel your appointment. Last minute cancellations do not allow the therapist enough time to book another client.

We understand that life can throw you an occasional curveball, and you may need to cancel your appointment with less than the 24 hour notice. In that event, we will allow **one** last minute cancellation, for every client. Therefore, any cancellations after that the client will be charged full price for the missed appointment (medical emergencies excluded).

We hope that you understand the need for this policy, and we encourage you to contact Suzette Skidmore at 720-696-0124 or Rachel Farmer at 914-282-3322 with any concerns regarding this policy.

Client Signature: _____ Date: _____

