Healing Solutions Inc™
Where You're Not Just a Body, You are Somebody

Confidential Client Intake and 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 # _____

==========

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 # _____

==========

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: _____

==========

Do you have any of the following today?

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

==========

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

What do you hope to accomplish from Today's Massage? _____

==========

The above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur. I also understand that a missed appointment will incur charges that I must pay based on the cancellation policy.

Signature _____ Date _____

Healing Solutions Inc™
Where You're Not Just a Body, You are Somebody

Policies and Procedures for Healing Solutions Inc.

Communication

1. 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.
2. 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.
4. 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.
5. 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

6. 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

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

Therapeutic Grade Essential Oils

8. 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

9. I understand that I need to be on time for an appointment. If I am late, the massage will be shorter, allowing the practitioner to finish on schedule. If the practitioner is running late, you will receive a full length session, unless you have a time conflict, in which case the time will be made up in another session.
10. I agree to provide 24 hours notice if I need to cancel an appointment or reschedule. See cancellation policy for specific guidelines.

Payment

11. 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.
12. I understand that I am responsible for full payment of services rendered by Healing Solutions Inc to me (the client).

Signature _____ Date _____

Healing Solutions Inc™
Where You're Not Just a Body, You are Somebody

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 curve ball, 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 with any concerns regarding this policy.

Client Signature: _____ Date: _____