Client Health Intake Form

Name_____ Phone (_____)_____ DOB_____

Address_____City_____State_____Zip_____

E-Mail_____

Referred by: _____ Phone (_____)_____

In Case of Emergency: _____ Phone (_____)_____

Occupation_____ ☐ Male ☐ Female

Physician_____

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.

Check off all that apply and explain as clearly as possible.

_____Do you frequently suffer from stress?

_____Do you have diabetes?

_____ Do you experience frequent headaches?

_____ Are you pregnant?

_____ Do you suffer from arthritis?

_____ Are you wearing contact lenses?

_____ Are you wearing dentures?

_____ Do you have high blood pressure

_____ Are you taking high blood pressure medication?

_____ Do you suffer from epilepsy or seizures?

_____ Do you suffer from joint swelling?

_____ Do you have varicose veins?

_____ Do you have any contagious diseases?

_____ Do you have osteoporosis?

_____ Do you have any allergies?

_____ Do you bruise easily?

_____ Any broken bones in the past two years?

_____ Any injuries in the past two years?

_____ Do you have tension or soreness in a specific area?

Please specify: _____

_____ Do you have cardiac or circulatory problems?

_____ Do you suffer from back pain?

_____ Do you have numbness or stabbing pains?

_____ Are you sensitive to touch or pressure in any area?

_____ Have you ever had surgery (explain on back)

_____ Do you have any heart or kidney failure/disease?

_____ Do you have any electrical implanted devices?

_____ Other medical condition, or are you taking any medications I should know about? _____

I understand that the 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 this 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 the 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 as 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 made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature_____ Date_____

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

Signature of Parent or Guardian_____Date_____