THE WELLNESS WITHIN MASSAGE

Confidential Client Intake Form
RMT Samantha Taylor

Full Name: _____ M / F Date of Birth: _____ Date: _____
Address: _____City:_____ Postal Code: _____

Preferred Contact Phone #: _____ Alt. Phone #: _____Contact Incase of Emergency: _____
Relation: _____ Number: _____

Would you like reminders for future appointments? _____
If yes, would you like to be reminded by ***email*** or by ***telephone***? (*please circle one)*
If you would prefer by email, email address: _____

Your occupation: _____
Typical exercise in a day:_____ Times per week: _____
Reason for todays visit: _____
Previous Injury?_____ How long ago? _____ ___
How long have you been feeling this way? _____
Have you received another form of treatment for stated reason? _____
If yes, what form of treatment? _____

CURRENT/PAST HEALTH CONDITIONS

(Please check ALL which apply):

____ Cancer ____ Diabetes ____ Epilepsy ____ High Blood Pressure ____ Low Blood Pressure

____ Heart Disease ____Stroke ____ Paralysis ____ Other *(Please specify):* _____

CHECK ANY THAT YOU EXPERIENCE ONCE OR TWICE PER WEEK:

____ Headache ____ Constipation ____ Diarrhea ____ Excessive Urination ____ Indigestion

____ Faintness/Dizziness ____ Tightness of Jaw ____ Grinding of teeth ____Clenching of Jaw

____ Weakness in body parts ____ Constant soreness in muscles ____ Fatigue ____ Insomnia

____ Heavy Feeling in limbs ____ Cold Hands/Feet ____ Lower Back Pain

For Woman: Pregnant? Y/N **How far along? _____** Allergies *(Please specify):*_____

Do you smoke? *(# Per Day?):* ___ Drink Coffee? *(Cups Per Day?):* ____ Drink Water? *(Cups Per Day?):* ____

MEDICATIONS *(Please List):*

_____
_____

VITAMINS *(Please List Brand Names):*

_____
_____

PLEASE READ AND SIGN:

THIS AGREEMENT AND THE CONTENT OF THIS FILE ARE CONFIDENTIAL. THE DATA WILL NOT BE SHARED OUTSIDE THIS PRACTICE WITHOUT CLIENT PERMISSION. THE INFORMATION IS TO ASSIST THE THERAPIST IN PROVIDING THE SAFEST AND MOST EFFECTIVE TREATMENT PLAN FOR YOU.

I, the client, understand that the registered massage therapist is providing services within their scope of practice.
I, the client, hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my therapist.
I, the client, understand that the therapist is not a physician and does not diagnose illness, disorder or disease. The treatment I receive does not substitute for medical exams and that it is recommended that I see a physician for any ailments that I may be experiencing.
I, the client, understand that some treatments may be contraindicated for certain medical conditions and I have stated all known medical conditions and answered all questions honestly, to the best of my knowledge.
I, the client, agree to keep my therapist updated on any changes to my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

NO SHOW AND CANCELLATION POLICY:

- There must be at least **6 business hours** notice for any cancellations
- Sending someone in your place is acceptable
- $20.00 less then the full scheduled appointment fee will be charged for missed appointments, without proper notification
- For **late arrivals**, you will receive the remainder of your appointment time and will be responsible for the full fee of the booked time.

Printed Patient Name: _____

Signature: _____ Date: _____

For those client's who are **under the age of 18**:

As the legal parent/guardian of _____, I hereby understand the content stated above and give permission to the therapist to treat such client.

Legal Parent or Guardian Printed Name: _____

Signature: _____