Wisebody Wellness Intake Form

Client Information

Name _____ Date _____

Street _____

City _____ State _____Zip _____ Referred By _____

Occupation _____ Date of Birth _____

Phone _____ Is it ok to send you text reminders for your appointment? □Yes □No

Email _____ Is it ok to keep in touch with you via email ? □Yes □No

Emergency Contact Name and Phone _____

List any exercise activities & frequency: _____

_____

Are you training for a specific event? _____

Have you had a recent surgery? □Yes □No If yes, when? _____

What for? _____

Are you currently receiving PT? □Yes □No If yes, what for_____

Are you taking any blood thinners (Aspirin, Ibuprofen, Coumadin)? □Yes □No

Injuries/accidents/illness still affecting you: _____

Prior Surgeries: _____

Skin

□ Allergies specify: _____
□ Rashes / Infections
□ Athletes foot / Warts
□ Herpes / Cold sores
□ Topical hormone or pain cream

Musculoskeletal

□ Bone or joint disease
□ Tendonitis / Bursitis
□ Arthritis / Gout
□ Jaw pain (TMJ)
□ Spinal Problems

Circulatory

□ Heart Condition
□ Phlebitis / Varicose veins
□ Blood Clots
□ High / Low Blood Pressure
□ Lymphedema
□Thrombosis / DVT / Embolism

Other

□ Pregnant: Trimester _____
□ Cancer / tumor
□ Breathing difficulty / Asthma
□ Diabetes
□ Migraines / headaches

Any other health concerns you think I should know about?_____

_____

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Session Information

What are your goals in seeking massage, craniosacral, reflexology therapy? _____

What type of pressure do you prefer? Light / Medium / Deep

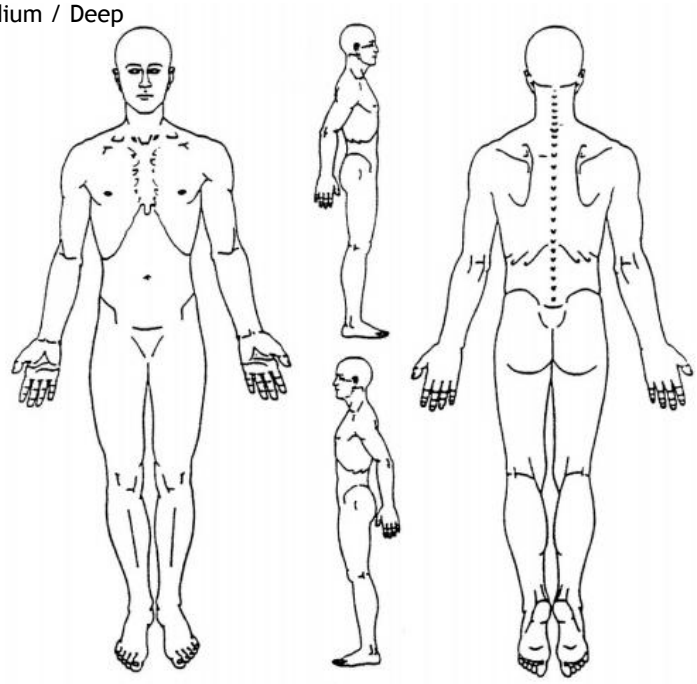
Please circle/indicate areas of pain or discomfort & briefly describe:

_____

When did symptoms appear?

_____

Rate severity of pain on a scale of 1 (least) to 10 (severe): _____



Type of Pain:

- □ Sharp _____
- □ Dull _____
- □ Burning _____
- □ Cramping _____
- □ Stiffness _____
- □ Shooting _____
- □ Tingling _____
- □ Throbbing _____
- □ Numbness _____
- □ Aching _____
- □ Swelling _____
- □ Other _____

How often do you have the pain? _____

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation/Exercise

Please describe activities or movements that are painful to perform:_____

□ Work □ Sleep □ Daily Routine □ Driving □ Recreation/Exercise

Informed Consent

- I have completed this form to the best of my knowledge and will inform my therapist of any change in my physical health.
- I understand that a licensed massage therapist can not diagnose illness, disease, or any medical, physical, or emotional disorder, nor perform any spinal manipulation. I am responsible for consulting a qualified physician or physical therapist for any physical ailments that I have.
- I understand that massage, craniosacral, and reflexology are therapeutic health aids and are non-sexual.
- I understand that Wisebody Wellness packages expire one year from date of purchase.
- I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.
- I agree to the following **Cancellation Policy**:

  I will be charged $45 if I cancel the day of my scheduled appointment.
  If I do not show up for my appointment and I do not cancel, I will be charged the full cost of the appointment. Emergency and illness cancellations will be taken into consideration.

Signed _____ Date _____