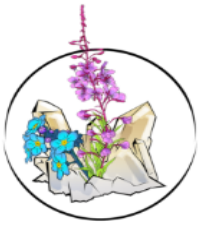

WILD QUARTZ WELLNESS

massage therapy & holistic healing

NEW CLIENT INTAKE

Name _____ D.O.B. _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Cell phone _____ Work phone _____

Email _____ Occupation _____

Employer _____ Referred by _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____

Insurance Information

Full Name_____ D.O.B. _____

Insurance Provider _____ Insurance ID #_____

Billing address_____

City_____ State _____ Zip_____ Phone_____

Client's relation to insured *(circle)* Self | Spouse/Partner | Child

What Brings You In?

Circle all that apply: Mental Relaxation | Tight Muscles | Injury Recovery | Wellness | Other

Please list any areas of concern _____

_____

Date of injury *(If applicable)* _____

Health History

Current Medications/Supplements and what are they taken for:

_____

_____

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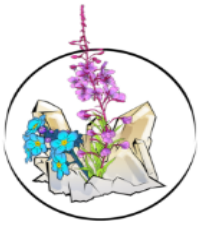

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List All Major Injuries (including broken bones/sprains/strains), Illnesses, Surgeries and Dates:

_____

_____

List any Accidents and Dates of Occurrence: (Were you injured? Did you see a doctor?)

_____

_____

Do you have sensitive skin? _____ Do you have any allergies to oils, lotions or ointments? _____

List any known allergies _____

Circle Any of the Following Conditions that Apply

Musculoskeletal

Bone or Joint Disease | Tendonitis | Bursitis | Arthritis | Gout | Jaw Pain (TMJ) | Lupus | Spinal Problems

Migraines | Headaches | Osteoporosis

Circulatory

Heart Condition | Phlebitis | Varicose Veins | Blood Clots | High Blood Pressure | Low Blood Pressure

Lymphedema | Thrombosis/Embolism

Respiratory

Breathing Difficulty | Asthma | Emphysema | Sinus Problems

Nervous System

Shingles | Numbness | Tingling | Pinched Nerve | Chronic Pain | Paralysis
Multiple Sclerosis | Parkinson's Disease

Reproductive

Pregnant, due date _____ Ovarian | Menstrual Problems | Prostate

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Skin

Rashes | Cosmetic Surgery | Athlete's Foot | Herpes | Cold Sores | Open Sores

Digestive

Irritable Bowel Syndrome | Bladder Infection | Kidney Problems | Colitis | Crohn's Disease | Ulcers

Psychological

Anxiety | Stress Syndrome | Depression | Mood Swings | OCD | Cold Sweats

Other

Diabetes | Cancer/Tumors - If yes, Location _____

Contact Lenses | Dentures | Hearing Aids

Any other medical condition(s) not listed: _____

_____

Disclaimer: If you've listed certain medical conditions or specific symptoms, massage may be contraindicated. In some cases, massage may be able to be resumed with a doctor's note of approval. If using insurance, a referral from your primary care provider may be required prior to service.

Previous Experience

Have you received a professional massage before? _____

If yes, how frequently? _____

If yes, when was your last massage? _____

Do you have any goals in mind with your massage session?

_____

_____

What is your favorite part of a massage?

_____

_____

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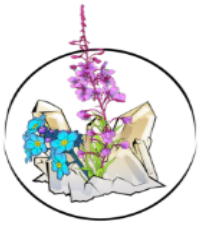

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What kind of pressure do you prefer? *(circle)* Light | Moderate | Firm

Client Agreement

I understand that the massage I receive is provided for relaxation and pain management. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure can be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination or diagnosis and that I should see a qualified medical specialist. Massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I 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. It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.

Print name _____ D.O.B. _____

Signature_____ Date _____

If Under 18 Years Old:

Parent/Guardian Name _____ Relationship: _____

Parent/Guardian Signature _____ Date _____

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