WILD QUARTZ WELLNESS
massage therapy & holistic healing

NEW CLIENT INTAKE

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

Address _____ City _____ State _____ Zip _____

Cell phone _____ Email _____

Occupation _____ Employer _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____ Referred by _____

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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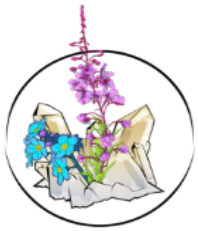
PH: 760.523.8500



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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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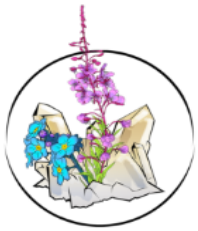

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Skin

Rashes | Eczema | 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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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.

Privacy Notice: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.

Print name _____ D.O.B. _____

Signature_____ Date _____

Consent to Treat a Minor

Parent/Guardian Name _____ Relationship: _____

Parent/Guardian Signature _____ Date _____

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Cancellation Policy

Due to the scheduling demands of our office, we require a 24 hour notice of cancellation for your scheduled massage or holistic healing service. We understand that things come up and if you are unable to make your scheduled appointment, please notify us as quickly as possible so we can make that appointment time available for another client.

_____ (initial) **If you notify us with at least 24 hours, you will not be assessed a late cancellation fee. If you notify us with less than 24 hours' notice, you are subject to a $45 late cancellation fee, due upon your next visit.**

_____ (initial) **If you fail to give notice and simply do not show up for your scheduled appointment, you will be responsible for 100% of the scheduled service, due upon your next visit. You will also be required to pre-pay for future bookings.**

The late fee and fee for a missed scheduled service cannot be billed to insurance companies and must be paid by you personally. Certain exceptions may be honored, please keep in contact with us in the event that something comes up.

I understand and hereby agree to abide to this policy.

Name: _____

Signature: _____ Date:_____

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