WHOLISTIC HEALTH
CONFIDENTIAL CLIENT INTAKE FORM

Name_____Address_____

City_____State_____Zip_____

Phone – home/cell_____Phone – Work/Cell_____

Date of Birth_____Occupation_____ E-mail: _____

Emergency Contact Information: Name:_____ phone number_____

Referred by?_____ Currently Under Physician's Care? ___ Yes ____ No

CURRENT HEALTH

Have you ever received massage treatments before? ___Yes___No

Reason for today's visit/area of concern_____

Is there anything I should know to ensure your comfort?_____

Currently taking any medications: __no __yes & for what conditions:_____

_____

CHECK ANY THAT APPLY TO YOUR CURRENT HEALTH

__Infections
__Bruise easy
__Arthritis
__Diabetes
__Asthma
__Eczema
__Psoriasis
__Ring Worm
__Fibromyalgia

__Varicose Veins
__Blood Clots
__Hepatitis
__Phlebitis/thrombosis
__Hearing problems
__Circulatory conditions
__Difficulty breathing
__Chronic Headaches
__High Blood Pressure

__Herpes/Shingles/Cold Sores
__Sinus Problems/Allergies
__Metal bones, pins or plates:_____
__Disc/Spine problems:_____
__Immune disorders:_____
__Heart conditions:_____
__Pregnant:____trimester
__Cancer:_____
__Warts __plantar warts ___nail fungus
__Other:_____

Please list any major:

Injuries:_____

Surgeries:_____

Other conditions not listed above:_____

Allergic to:_____

Sensitive to:__oils/lotions ___scents, what kind:_____ Wear Contacts:__yes__no

Cancellation Policy: If an appointment is cancelled with less than 12 hours notice, or missed without canceling (no Show), we reserve the right to charge the client 50% of the appointment cost. We also request that you arrive early for your appointment. In order for us to uphold our professional standards of being on time, we regret that we cannot give you additional time if you arrive late for your appointment. If for any reason we are late starting your appointment, you will receive the full scheduled time or be compensated for the time missed.

CONSENT FOR CARE: It is my choice to receive treatments. I am aware of the benefits and risks and give my consent. I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that esthetic skin care/or massage is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my therapist of any changes in my health status. Your signature below gives consent to Wholistic Health to provide information to your primary care physician upon your verbal request. I understand that at any time the therapist can end the session if I am inappropriate in my behavior.

_____ _____

SIGNATURE DATE