Pure Wellness Client Intake Form

Name: _____ Date:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Date of Birth: _____ Occupation: _____

When was your last massage or reiki session? (If first time, leave blank) _____

Do you use essential oils (if yes, please list)_____

_____

Main goal today: _____

Preferred Music: ☐ Classical ☐ New Age ☐ Spa ☐ Bring my own ☐ Any ☐ None

Preferred Appointment Days and Times: _____

Preferred Contact when confirming appointments: ☐ Call ☐ Text ☐ Email_____

If you are currently under the care of a Health Care Provider:

Name _____Telephone # _____

Permission to Consult with Primary Provider? No ☐ Yes ☐ (please initial if yes)

In Case of Emergency, Please Notify:

Name: _____ Telephone: _____

I, _____, (client) understand that massage therapy provided by, Cathy Podd, L.M.T. is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

Massage: The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

Reiki: I understand that Reiki is a simple, gentle, hands-on energy technique that is used for stress reduction and relaxation. I understand that Reiki practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. I understand that Reiki does not take the place of medical care. It is recommended that I see a licensed physician or licensed health care professional for any physical or psychological aliment I may have. I understand that Reiki can complement any medical or psychological care I may be receiving. I also understand that the body has the ability to heal itself and to do so, complete relaxation is often beneficial. I acknowledge that long term imbalances in the body sometimes require multiple sessions in order to facilitate the level of relaxation needed by the body to heal itself.

Policies and Procedures: I have read ,understand and agree with the policies and procedures on the website.

_____ _____

Client Signature Date

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

MusculoSkeletal
o Headaches
o Migraines
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Strains/sprains
o Back, hip pain
o Shoulder, neck, arm, hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Tendinitis
o Bursitis
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease
oOther: _____

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Cold sweats
o Swollen ankles
o Pressure sores
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Allergies
o Sinus problems
o Asthma
o High blood pressure
o Low blood pressure
o Lymphedema
o Sensitivities: _____
oOther: _____
oPlant sensitivities: _____

Skin
o Rashes
o Allergies
o Athlete's Foot
o Warts
o Moles
o Acne
o Cosmetic surgery
o Sensitive to touch
o Other: _____

Digestive
o Nervous stomach
o Indigestion
o Constipation
o Intestinal gas/bloating
o Diarrhea
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Colitis
o Adaptive aids
oOther: _____

Nervous System
o Numbness/tingling
o Twitching of face
o Fatigue
o Chronic pain
o Sleep disorders
o Ulcers
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Chronic Fatigue Syndrome
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury
oOther: _____

Reproductive System
o Pregnancy:
  o Current
  o Previous
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Thyroid (hypo,hyper)
o Autism
o ADD/ADHD
o Tourettes
o Bipolar Disorder
o Anxiety
o PTSD
o Depression
o Difficulty concentrating
o Drug use _____
o Alcohol use _____
o Nicotine use _____
o Caffeine use _____
o Hearing impaired
o Visually impaired
o Burning upon urination
o Bladder infection
o Eating disorder
o Diabetes
o Fibromyalgia
o Post/Polio Syndrome
o Cancer
o Infectious disease (please list)
_____
o Other congenital or acquired disabilities (please list) _____
_____
o Surgeries _____
o Other: _____

Please list any medications or additional comments regarding your health and wellbeing:

_____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____Date:_____