

Client Information

Welcome to First Hand Healing! We would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions please let us know.

Name _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ E-mail _____

Is it ok for us to contact you at the above information? **Yes** **No** Would you like our Newsletter? **Yes** **No**

Occupation _____ Male ___ Female

Have you ever received a professional massage before? _____ How long ago? _____

How did you learn about First Hand Healing? _____

Are you currently seeing a healthcare professional? ___ Yes ___ No

Physician's name _____ Phone Number _____

Do we have your permission to contact your doctor? ___ Yes ___ No

Health Insurance Provider _____

Emergency Contact _____ Phone _____

Please take a moment to carefully read the following information and check where applicable. If you have a specific medical condition or symptoms, massage/bodywork may be contraindicated and a referral from your physician may be required prior to receiving treatment.

___ Allergies/Sinus

___ Blood Clot

___ Fibromyalgia

___ Arthritis

___ Varicose Veins

___ Contagious Disease

___ Autoimmune Condition*

___ Diabetes (type ___)

___ Skin Rashes

___ Osteoporosis/pena

___ Epilepsy/Seizures

___ Muscle Spasms

___ Stroke

___ Frequent Headaches

___ Bruise easily

___ Cancer

___ Migraines

___ Bulging/Herniated Disc

___ Cardiac or circulatory condition

___ Swelling or Edema

___ TMJ/Jaw pain

___ High Blood Pressure / Meds

___ Hepatitis (A,B,C, other)

___ Pregnant

(*MS, thyroid condition, Lupus, Rheumatoid etc)

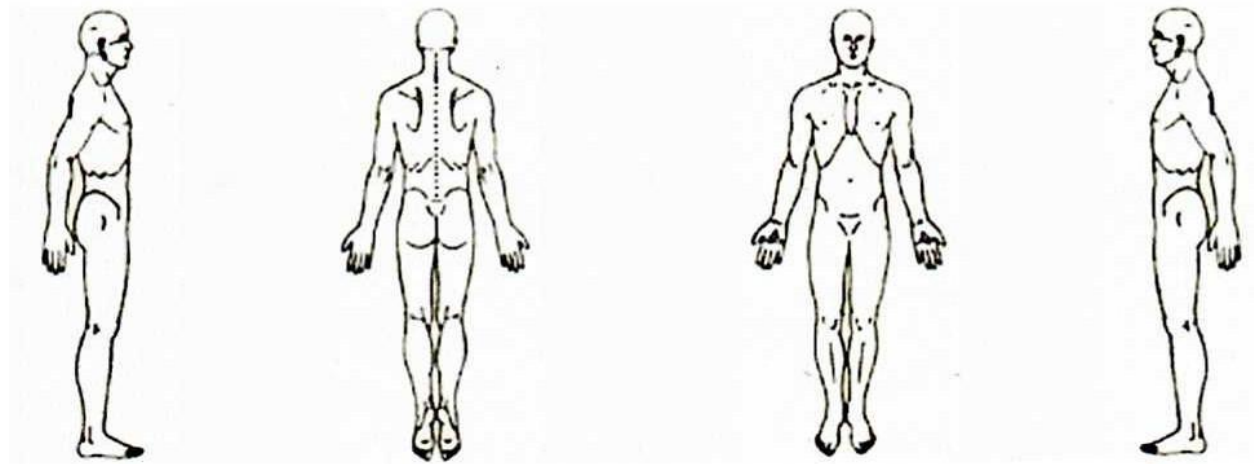
Other Medical Conditions: _____

Have you had any surgeries/hospitalizations? (Please explain) _____

Have you recently suffered an accident or injury? _____

Are you currently on any medications? _____

Please indicate with an "X" if there are areas in which you feel pain or discomfort.



Please describe what type of pain you are experiencing, (numbing, tingling, aching) _____

What type of pressure do you prefer in your massage? ___ Light ___ Moderate ___ Deep

Check any area listed below that you **do not want** worked on during your 'Full Body' massage.

___ Face ___ Neck ___ Chest ___ Abdomen ___ Legs ___ Arms ___ Hands ___ Back ___ Pelvis ___ Feet

Comments: _____

I have completed this intake form to the best of my knowledge. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and or relief of soft tissue/muscle conditions. If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the pressure may be adjusted to my level of comfort. I further understand that massage or bodywork services are a therapeutic health aid and are non-sexual; it is not a substitute for medical examination or diagnosis, nor is it a substitute for a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I agree to keep the practitioner updated on my medical profile and understand that there shall be no liability on the practitioner's part for my medical conditions. I also understand that if any illicit, sexually suggestive remarks or advances are made by me, it will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ **Date** _____

Consent to treatment of a minor. By my signature below, I hereby authorize _____ to administer bodywork to my child or dependent as they deem necessary.

Parent or guardian: _____ Date: _____

I understand a 24-hour notice is requested to cancel or reschedule my appointed treatment. Late cancellations, with the exception of extreme emergency or illness, will result in a **\$40** fee. This fee will be waived if your appointment can be filled by a relative, friend, or colleague you wish to send in your place, or if we can fill this time for you.

Client Signature _____ Date _____