Healing Hands Massage Therapy
Personal Data and Health Screen **Intake Update** **CONFIDENTIAL**

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

E-Mail:_____ **Do I have permission to add your email to my list?** _____

Phone:(work) _____ **(home)** _____ **(cell)** _____

Date of Birth: _____/_____/_____ **Marital Status Please Circle: Single Married Divorced**

Occupation:_____ **Employer:**_____

Name of Spouse/Significant Other:_____

Preferred Appointment Day and Time: _____

Referred By: Please circle Internet Website Person:_____

In Case of Emergency: Name & Relationship:_____**Phone**_____

How may I contact you? ____text ____phone ____email _____mail **This gives me permission to contact you per your preference.**

Can I leave a voice message on your phone? YES NO With Anyone? _____

Please List <u>Any Changes</u> You Have Had In Any Of The Areas Below Since Your Last Visit
Use back of page if need more room for description of changes

-1. Exercise habits:

-2. General diet:

-3. How well you sleep:

-4. Your general health:

-5. How are your bowels?

-6. Posture assumed most of day:

<u>Medical Health History</u>: Events since your last visit Please Explain and GIVE DATES

-Describe any surgeries or hospitalizations:

-Describe any injuries or accidents:

-What kind of care did you receive?

-Do you consider that you have recovered from these events? Please explain

-Do you have any *<u>NEW</u>* muscle pain and/or stiffness? Explain

-Do you have any *<u>NEW</u>* chronic, ongoing conditions that you deal with on a regular basis? Please explain.

- Please list all medications (including aspirin) that you are currently taking and list for what condition. Also include herbal/nutritional supplements.

_____
_____
_____
_____

- **Are you a diabetic? YES or NO**
- **Do you have high blood pressure? YES or NO**
- **Do you have cardiac or circulatory problems? YES or NO**
- **Do you have high cholesterol? YES or NO**
- **Do you have any contagious, infectious or systemic illnesses? YES or NO**
- **Do you have any skin rashes or other skin problems right now? YES or NO**
- **Do you experience frequent headaches? If yes, please fill out headache questionnaire YES or NO**
- **Are you pregnant? YES or NO**
- **Are you currently seeing a doctor for any reason? Please Explain YES or NO**

_____
_____

Please list your physicians name, address and phone number:

Name:_____
Address:_____
Phone:_____

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Healing Hands Massage & Holistic Therapies Name:_____
Policies and Disclaimer Print Name

Please initial each policy to say that you read and understood the policy

- _____ All information you give to me will be treated confidentially. At no time will any of your information be sold to third parties. In order to maximize the effectiveness and safety of your massage session, please give feedback before, during and at the end of the each session. This will help me to better understand your needs and how to better help you in the best possible way.

- _____ If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

- _____ **I understand that giving 24 hours or more notice for cancellations or rescheduling will not result in any charge for that appointment**.

- _____ ***Any missed appointment without 24 hours notice* will result in a charge of the scheduled session cost**.

- _____ Punctuality will assure full use of the allotted time. I allow 15 minutes for tardiness before I mark you as a No Show. I will make a phone call to the phone number on your chart to see if you are coming and if needed to reschedule. Any missed time due to you being late will be deducted from your session time. You will still be charged the same session price. If I am running late; you will still get your full session time. If session missed, refer to charge for service above.

- _____ Missed appointment and clients running late is not only a hardship for your therapist but it's also unfair to those other clients who have an appointment after you or those on my waiting list who would have liked to have been notified of the opening.

. _____ Any returned check will result in a charge of **$25.00**; I will then only be able to accept cash or credit cards for payment.

I have read the above information and will discuss it with my practitioner. I understand that massage/movement therapies I receive are provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that massage/movement therapies should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/movement therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/movement therapy 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 therapists part should I neglect to do so. I understand that massage/ movement therapies are designed to be health aids and do not constitute medical treatment. I understand that information exchanged during massage sessions is educational in nature and intended to help me become more familiar with and conscious of my own health status, and is to be used at my discretion. I take responsibility for alerting my therapists immediately if I am feeling ill. I understand that I cannot hold my practitioner liable for undisclosed conditions or irresponsible acts I might perform. It is also understood 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.

Signature: _____ **Date**_____ **Therapists int**. _____

I, _____ give Sarah Otis permission to use Therapeutic Grade Essential Oils and/or Aromatherapy on me during my therapy sessions. I have the right to refuse the use of any and all essential oils at any time if I so chose to. I will notify Ms. Otis of my wishes, I will not hold her liable for any side effects theses oils may cause or any disruption in my medications. I will immediately notify her if I am experiencing any side effects.

Signature: _____ Date_____ Therapists int. _____

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Healing Hands Massage & Holistic Therapies
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423-646-9961

General Release of Information

Today's Date: _____

Client Name: _____ **Please Print**

Please initial each and sign at the bottom

_____ I give Healing Hands Massage & Holistic Therapies permission to speak or exchange any and all needed information pertaining to my current health conditions that I am seeing my regular physician for, **only if the need arises**.

ANYTHING NON-HEALTH RELATED DISCUSSED DURING INTAKES OR SESSIONS <u>WILL NEVER BE DISCUSSED</u> WITH YOUR PHYSICAN <u>UNLESS</u> YOU ARE POSING A HEALTH RISK TO YOURSELF.

_____ I give Healing Hands Massage & Holistic Therapies permission to call my physician, 911 or my Emergency Contact Person on file during an emergency situation for assistance. Only the needed information will be released for your care.

_____ I give Healing Hands Massage & Holistic Therapies permission to mail my physician a letter stating that I am receiving therapeutic massage from Sarah E. Otis, CMT, LMT, NCTMB. This allows my physician an opportunity to voice any concerns about my current health conditions and if they feel it contraindicates my receiving massage. A letter will only be sent if Sarah Otis has concerns about your current health or medical conditions and/or medications.

Physician's Name, Address and Phone Number:

_____

_____

_____

Emergency Contact Person & Relationship to you, Address and Phone Number:

_____

_____

_____

I understand that I may withdraw this consent at any time except to the extent that the authorized parties have already acted in reliance on it.

This authorization will automatically terminate in **one year** (**12**) months, at that time you will need to sign another release of information

_____ _____

Name Date

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