Shade of Green Healing
220-HEAL (4325)

Client Intake Form

Date_____

Name_____

Address_____

City, State, Zip_____

Phone (Day)_____ Phone (Evening)_____

E-mail _____

How did you hear about us?

_____

Reason for your visit/expectations

_____

Health History

Medications currently taking (include over-the-counter medications and dosage)

_____

_____

_____

Reason for medication(s)

_____

_____

List any surgeries and approximate dates

_____

_____

Are you Pregnant? _____ Did you use birth control prior to becoming pregnant? _____

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Place an **X** next to any of the following conditions you suffer from: *All information is confidential*

___Headaches ___Fatigue ___Sleeplessness ___Seizures

___Back Pain ___Allergies ___Arthritis ___Cancer

___Neck Pain ___Joint Disease __Sinus Infections ___Asthma

___Swelling ___Stress ___Heart Disease ___Fainting

___Blood Clots ___Numbness ___Skin Rash ___Fractures

___High Or Low Blood Pressure ___Concussion ___Digestive Disease

____Other

_____

_____ _____

Elaborate on indicated ailments

_____

_____

_____

List all medical conditions that are not indicated above. It is important you provide full disclosure for your own safety because some conditions maybe complicated by massage.

_____

_____

_____

During your massage session, the therapist may be working on the following parts of your body, using appropriate draping for your safety and comfort. Please check any areas you to **NOT** feel comfortable having the therapist work.

___ Neck ___Shoulder ___Back ___Arms ___legs ___chest

___Abdomen ___Feet ___Gluteals other: _____

I have informed the practitioner of all conditions I am currently aware of and attest that this information is accurate and true. Therapists will not prescribe any medication, will not perform any spinal manipulations, and will work within their scope of practice, abiding by all laws, rules and regulations that apply. Lease sign and date below.

_____ _____

Client Signature **Date**

_____ _____

Practitioner Signature **Date**