LOW TIDE BODYWORK

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Client & Health History Intake Form

Name _____ Phone _____Date_____

Address, city, state & zip code_____

Best phone contact#_____Date of birth_____

Email address_____ Occupation_____

Emergency contact name & phone#_____

Please check present conditions:

	Arthritis		**Migraines**		**High/Low blood pressure**
	Carpal tunnel syndrome		**Dizziness/fatigue**		**Neuropathy**
	Sciatica		**Shingles**		**Cancer**
	Skin disorders, Herpes, TB		**Easy bruising**		**Lymph nodes removed. Where? Port?**
	Digestive Problems/constipation		**Hernia**		**Unexplained pain, Where?**
	Varicose veins		**Respiratory disease**		**Blood clots**
	Seizures		**History Hepatitis**		**Anxiety**

Are you feeling ill today? _____Fever?_____

Do you have allergies? _____To what?_____ Reactions? _____

Are you allergic to oils/chlorine? _____

Any major injury or illness? _____Describe_____

Side effects of current medications? _____

What is your current stress level? 1_____3_____5_____7_____10_____

Describe movements/activities that are painful _____
Is there any place you do NOT want massaged?_____

Have you ever had adverse reactions to massage in the past? _____Explain
_____

Current pain_____ Where?_____

What is your goal/expectation today?_____

PLEASE INTIAL/SIGN RELEASE of LIABILITY

I understand that massage can produce effects other than relaxation, such as muscle soreness and detoxification (possible skin rash). I will consult with the therapist if this occurs and seek other care if necessary. Initials_____

I understand that treatment is non-sexual, and primarily intended for relaxation and stress reduction. Services do not include psychiatry, diagnoses, spinal manipulation, or medical intervention. Initials_____

I have notified my therapist of known medical conditions and injuries. If I experience pain/discomfort during the session, I will immediately inform the therapist so pressure will be adjusted. I will not hold my therapist responsible for pain/discomfort I experience during or after session. _____

I understand that there is no guarantee of effectiveness/success for treatment. By signing this release I waive and release my therapist from any liability relating to bodywork. _____

Treatments may be covered by medical insurance, and it is my responsibility to confirm details of coverage. _____

I understand that if I do not give 24 hours' notice of cancellation, I will be charged for full visit. Initials_____

Client name_____

Signature of Client_____ DATE_____