

Artizen Yoga & Massage

MYOFASCIAL RELEASE – REIKI – THERAPEUTIC MASSAGE HEALTH INTAKE FORM- CONFIDENTIAL INFORMATION

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____

CELL PHONE: _____ TEXT ME (circle one): YES or NO

EMAIL: _____ EMAIL ME: (circle one): YES or NO

OCCUPATION: _____ DATE OF BIRTH: _____

HAVE YOU EVER RECEIVED THERAPEUTIC BODYWORK? (circle one): YES or NO

TYPE OF BODYWORK RECEIVED (Massage, Energy Healing, etc.): _____

ARE YOU CURRENTLY SEEING A HEALTHCARE PROFESSIONAL? (circle one): YES or NO

IF YES, PLEASE LIST DIAGNOSIS, AND DESCRIBE TREATMENTS, MEDICATIONS, ETC. _____

PLEASE LIST ALL SURGERIES: (Surgery leads to the formation of scar tissue and myofascial adhesions, both of which can cause substantial pain and stress for years after the surgery. For best results, be as thorough as possible): _____

PLEASE REVIEW THE LIST BELOW AND INDICATE ANY THAT HAVE AFFECTED YOUR HEALTH WITH A CHECK MARK:

____ ACNE ____ ALLERGIES ____ ANEMIA ____ ANXIETY ____ ARTHRITIS ____ ASTHMA ____ BELL Palsy

____ BLOOD CLOTS ____ BROKEN/DISLOCATED BONES ____ BRUISE EASILY ____ CANCER ____ CHRONIC PAIN

____ COMMUNICABLE DISEASE ____ DIABETES ____ DIGESTIVE DISORDERS ____ ENDOCRINE DISORDERS

____ FIBROMYALGIA ____ FUNGAL INFECTION ____ HEADACHES ____ HEART CONDITIONS ____ HERNIA

____ HERNIATED DISC ____ HIGH/LOW BLOOD PRESSURE ____ HIVES ____ HYPO/HYPERGLYCEMIA ____ IBS

____ INSOMNIA ____ MASTITIS ____ MENTAL DISORDER ____ MULTIPLE SCLEROSIS ____ MYOFASCIAL PAIN

____ OSTEOPOROSIS ____ PARESTHESIA ____ PARKINSON DISEASE ____ PREGNANCY ____ ROSACEA

____ SCOLIOSIS ____ SEIZURE DISORDER ____ SHINGLES ____ SKIN CONDITIONS ____ SPRAIN/STRAIN

____ STROKE ____ TMJD ____ TOS ____ TORTICOLLIS ____ TUMOR ____ WART ____ WHIPLASH

DATE(S) (OR AGE) OF ABOVE PATHOLOGY AND PROGNOSIS: _____

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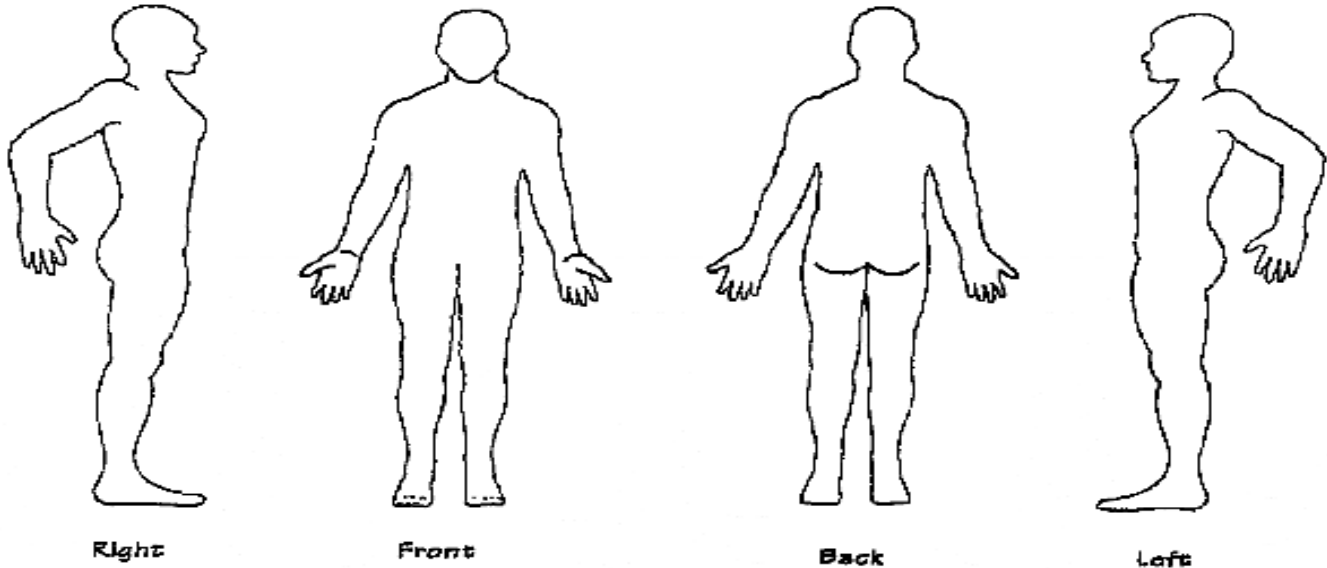
DO YOU HAVE ANY OF THE FOLLOWING TODAY:

SKIN RASH COLD/FLU OPEN CUTS/SORES (include bug bites and scratches)
 SEVERE PAIN ANYTHING CONTAGIOUS INJURIES/BRUISES

ON THE DIAGRAM BELOW:

PLEASE **CIRCLE** AREAS OF CHRONIC DISCOMFORT YOU WOULD LIKE ME TO FOCUS ON FOR TREATMENT

PLEASE INDICATE WITH AN **X** ANY AREAS OF ACUTE PAIN



WHAT ARE YOUR GOALS FOR A TREATMENT PLAN (I understand it will likely take more than one session):

The following sometimes occur during Myofascial Release / Reiki / Therapeutic Massage sessions.

Trust your body to express what it needs, and allow:

Sighing, yawning, changes in breathing <> falling asleep <> memories <> energy shifts
emotional feelings and/or expression <> the need to move or change positions
temperature changes <> stomach gurgling <> movement of intestinal gas

Please read the following information and sign below:

1. I understand that Myofascial Release/ Reiki / Therapeutic Massage can be therapeutic, may reduce stress, may reduce muscular strain, could cause pain to scar tissue, etc. It is not a substitute for medical examination, diagnosis, and medical treatment.
2. Being that Myofascial Release / Reiki / Therapeutic Massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

SIGNATURE: _____ DATE: _____

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CONSENT TO TREAT AND WAIVER:

PLEASE TAKE A MOMENT TO READ AND INITIAL ALL OF THE FOLLOWING STATEMENTS:

_____ If I experience pain or discomfort during the session I will immediately inform my therapist so that pressure, the temperature of the table, position of the face cradle and/or bolstering can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort.

_____ I understand that the services offered today are not a substitute for medical care, and are intended as a complement to any medical treatment I am currently receiving. I understand that my therapist will not perform any skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

_____ I affirm that I have notified my therapist of all known medical conditions and injuries.

_____ I agree to inform my therapist of any changes in my health and medical conditions. I understand that there shall be no liability on the therapist's part should I fail to do so.

_____ I understand that treatments offered by Artizen Yoga & Massage are purely therapeutic and non-sexual in nature. Treatment sessions will be terminated in the case of any inappropriate or threatening actions.

_____ By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to treatments.

_____ I understand that should I cancel an appointment less than 24 hours before the scheduled time or miss an appointment without sufficient notice I am subject to a fee equal to the cost of the missed appointment.

INFORMATION AND SUGGESTIONS:

1. Please remove all jewelry and pull up long hair in a high ponytail.
2. You may be more comfortable and better able to relax if you remove contact lenses and/or hearing aids.
3. You will be covered and draped with a top sheet modestly and respectfully throughout the massage, but please undress only to your comfort level, and ask your therapist if you have any questions.
4. Feel free to ask your therapist any questions before, during, or after the session. But, don't feel that you have to speak during the session. It is perfectly acceptable to quietly doze off and enjoy the treatment.

I HAVE RECEIVED AND REVIEWED THE POLICY STATEMENT, AND I HAVE READ AND AGREE TO THE ABOVE POLICIES:

CLIENT NAME (print): _____

CLIENT NAME (signature): _____

DATE: _____

THERAPIST SIGNATURE: _____