Inside Out Holistic Healing Studio

Confidential Intake and Health Form

Date: _____

Name: _____ Birth Date: _____

Address: _____ E-mail: _____

City: _____ Postal Code: _____ Phone (H):_____

Occupation: _____ Phone (W/C):_____

Whom may we thank for your referral/Where did you hear about us?_____

Emergency Contact Name: _____ Phone: _____

Physicians Name: _____ Phone:_____

Medical History – Please check the conditions that you experience frequently or are currently experiencing

□ Allergies, sensitivity
Specify _____
□ Asthma
□ Respiratory problems
□ Sinus problems
□ Abnormal skin conditions
□ Elimination problems
□ Hemorrhoids
□ Crohn's disease

□ Low back and/or knee pain
□ Osteoporosis
□ Urinary problems/infections
□ Phobias/Fears
□ Nervous problems
□ Ear Problems
□ Wake up many times at night
□ Sexual/reproductive dysfunction

□ Anemia
□ Arthritis (specify) _____
□ Candida
□ Cancer
□ Chronic Fatigue Syndrome
□ Diabetes _____
□ Hypo/Hyper Thyroidism

□ OTHER _____

Major Trauma (auto, fall etc)

_____

_____

□ Digestive complaints
□ Bowel Mvmt □daily □other
□ Food cravings (specify)

_____
□ Feeling of heaviness in body
□ Mental fatigue
□ Varicose veins
□ Bruise easily

□ Swollen lymphatic glands
□ Hypersensitivity
□ Rashes/hives
□ Swelling or cold extremities
□ Circulation problems

□ Epilepsy
□ Fibromyalgia
□ Headaches, migraines
□ Mental health issues
(specify) _____
□ MS

Females:
□ Menstrual Problems (eg. cramps) _____
□ Menopause

Surgery (type, date)

_____

_____

_____

□ Heart problems (specify)

_____
□ Low Blood Pressure
□ Palpitations
□ Insomnia, difficulty falling asleep
□ Dream disturbed sleep
□ Anxiety
□ Distention in lower abdomen

□ High Blood pressure
□ Dizziness
□ Anger/irritability
□ Stiff Joints
□ Jaundice
□ Sore eyes
□ Brittle nails
□ Wake up early then fall asleep again

□ Tendonitis (specify)

_____
□ Sprains/strains

_____
□ Recent injuries

_____

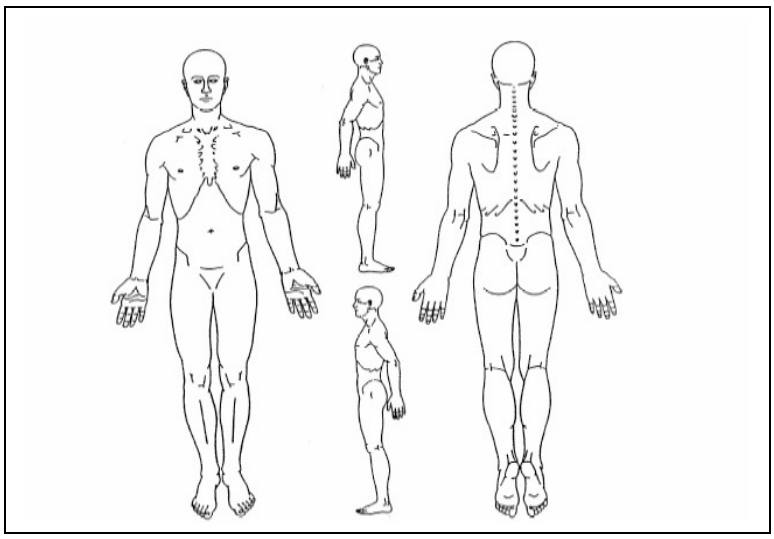
Family History: (diabetes etc.)

_____

_____

Please Indicate Area Requiring Attention Using the following Legend

XX Pain = Numb //// Stiff



Medications (incl. herbs, vitamins)

_____

_____

Briefly describe condition(s) requiring attention.

_____

_____

Are you also seeing __Chiro __Physio__Naturopath

__Massage _____

__Other. If so, whom? _____

Informed Consent to Body Therapy

I understand that the chosen modality of treatment I receive is provided for the well being of my body and mind. This includes relaxation, stress reduction, muscular tension, spasm/pain and improving circulation.

I understand and am informed that in the practice of Oriental Bodywork there are some possible physical, emotional and mental side effects that may occur. I do not expect the therapist to be able to anticipate and explain all risks and complications. I rely on the therapist to exercise her best judgment during the course of the procedure, which she feels at the time based upon the facts then known, is in my best interest. I further understand that the results are not guaranteed.

If I experience any pain during this session, I will immediately inform the practitioner so that the work can be adjusted to my level of comfort. I also may request that the session discontinue at any time, for any reason and the therapist will honor that request.

I understand that Certified Holistic Health Practitioners and Registered Shiatsu 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.

I further understand that Massage/Oriental bodywork should not be used as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of.

Because Massage/Oriental bodywork can be harmful under certain medical conditions, I affirm that I have stated all my known medical conditions, answered all questions honestly, and understand that there shall be no liability on the practitioner's part should I forget to do so.

I have read the above consent. I have had the opportunity to ask questions about its content and by signing below, I agree to the included procedures. I intend this consent form to cover the entire course of my treatment plan.

Client Name (please print):_____

Client Signature: _____ Dated: _____

Therapist Signature: _____ Dated: _____