Ingrid's Healing Hands

Client Contact Information & Health Information

Client Name: _____

Address: _____

Phone#: _____

Emergency contact name/number:_____

Email: _____

Would you like to be added to my email mailing list to be notified of any future discounts/promotions/workshops)?

Yes __ No ___

Date of Birth: _____ Referred by: _____

Massage Information

Today's Date: _____

Have you ever received professional massage/bodywork before? Yes __ No __

How recently? _____

What are your goals/expected outcomes for receiving massage/bodywork? Circle all that apply

Relaxation/Restoration Overall Wellness Stress Reduction Pain Reduction

Current physical areas causing discomfort? (ex: Sciatic Pain, Low Back, Neck, Shoulders, numbness/tingling, swelling)

_____

Current emotional & mental state? (ex: fatigue, depressed, sad, angry, grief, stressed, anxiety, etc)

_____

Are you pregnant? Yes __ No ___

If Yes, Today I am ___number of weeks, in my (circle) 1st 2nd 3rd Trimester

Any special circumstances I should know about this pregnancy?_____

List the medications you currently take:

_____

Have you had any injuries or surgeries in the past year that may influence today's treatment?

_____

Please circle conditions that you have (current or past): If you are unsure, please ask- it is important as massage may not be indicated for these conditions: blood clots, infections, congestive heart failure, contagious diseases, pitted edema, Recent Fever, Recent infection, Recent Trauma. In addition, the more I know the more I can customize a plan for your unique experience.

Therapist's Notes:

Ingrid Wilson, HHP, CMT, Reiki Master

Accidents/Injuries (ex. broken bones): Date_____

Allergies

Allergic/Sensitivities to any herbs/oils/essential oils_____

Arthritis (rheumatoid, osteoarthritis)

Asthma

Bronchitis

Bruise easily Sensitive to touch/pressure

Cancer/Tumor (circle treatment: chemo/radiation/other_____)

Carpal Tunnel

Digestive conditions (e.g. Crohn's, IBS)

Emotional Disorders (_____)

Diabetes

Epilepsy, seizures

Fibromyalgia

Headaches, Migraines

High/Low blood pressure

Insomnia

Multiple Sclerosis

Osteoporosis, degenerative spine/disk

Stroke, heart attack: Date_____

Varicose veins

Other:_____

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Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure may be adjusted to my level of comfort. I further understand that Massage/Bodywork/Reiki should not be construed 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 of which I am aware. I understand that Massage/Bodywork/Reiki practitioners 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/Bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand 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. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____Date: _____