CLIENT INTAKE

INTEGRATIVE HUMANCARE

Name: Last:_____ First:_____MI____ Nickname: _____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Phone: Mobile (_____)_____ Cell Provider:_____ Home: (_____)_____

E-Mail: _____ Work: (_____)_____

Gender: M / F Date of Birth: / /

Emergency Contact Person:_____ Emergency Phone: (_____)_____

Who Referred you? _____

PRESENT CONDITION:

Current discomfort (muscle / joint ache) ?

_____

_____

Pain Type: ____ Deep Ache ____ Burning/Stabbing ____ Numbness

Other areas of pain or concern ?

_____

_____

When did you first notice your primary complaint ? ____ Days ____Weeks ____Months ____Years

What brought it on ?

_____

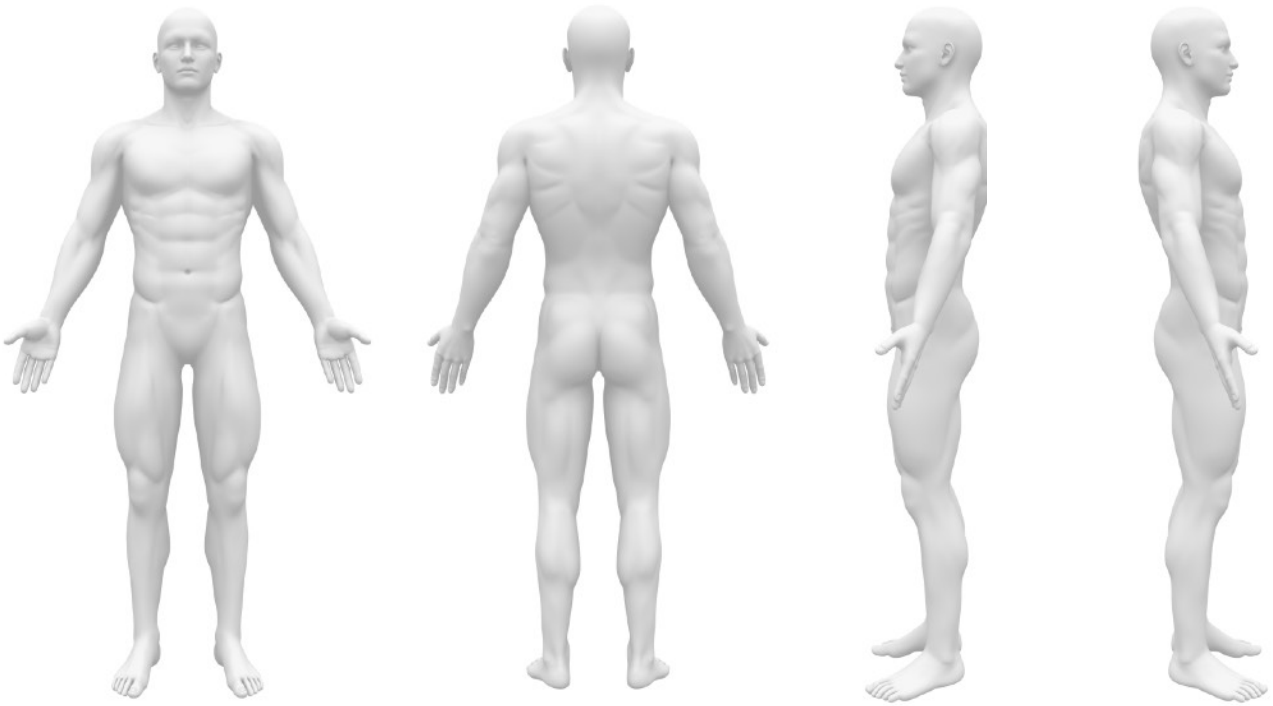
What activities aggravate your condition ?

_____

Is it getting progressively worse ? Yes / No Is the condition: ____ Constant _____ Intermittent

Is this condition interfering with: ____ Work ____ Sleep ____ Daily Routine

Shade In / Mark where you pain & discomfort are:



CURRENT CONDITIONS

High Blood Pressure / Hypertension ? _____

Heart Condition ? _____

Cancer ? _____

Diabetes ? _____

Varicose Veins ? _____

Thrombosis ? _____

Asthma / Bronchitis ? _____

Rheumatism ? _____

Thyroid Condition ? _____

Spinal Condition / Fusions ? _____

Open Wounds / Blood Clotting / Aneurysm ? _____

Currently Pregnant / What stage ? _____

PAST SURGERIES / EXISTING CONDITIONS / EXISTING DISEASE

ACCIDENTS / INJURIES / TRAUMATIC LIFE EVENTS

MEDICATIONS:

Name of Medication	Dose (mg)	Frequency (per day)	Reason (i.e. Blood Pressure)

The information I have provided above is accurate.. I understand that massage therapists do not diagnose or treat disease, and that any care or recommendation from this facility or from my therapist is not a substitute for a physician's care. I take responsibility for alerting my therapist of any changes to my health status and medications, as well as any responses perceived to be a result of the treatment as soon as I become aware of them. I will alert my massage therapist of any discomfort in both pressure and technique if there is any physical or emotional discomfort. The staff reserves the right to refuse services at its discretion based on client's conditions, therapist's skill set, client behavior or action without explanation or prior notice, and I agree to this policy.

Client Signature

Date

CLINIC POLICIES

On-Time promptness is both offered and expected in our practice. We honor your session and treat it as an investment; it must be valued.

CONDUCT
We have a zero tolerance for any suggestive behavior. Any sensual or sexual comments or actions will be grounds to terminate the session. Full payment will be due.

CHILDREN / YOUNG ADULTS
We continue to facilitate effective results for our youngest and eldest clients. For treatment of those 18 and under, we ask that a parent or guardian be present at all times within the treatment room during the service.

LOBBY: While we love children, our environment (being zen and clinical) is not conducive to children waiting for parents in service. As such, we ask that alternate child care sitting plans are made.

PAYMENT
Payment is due upon completion of service. Our preferred method of payment is cash or check (local check only). We also accept Visa, MC, AMEX, Discover and Debit Cards (with Visa or MC insignia).
Fees: $25. fee for returned checks

Gift Certificates as well as discounted Memberships and Multipass Series are also available: Please see "Benefits & Rewards" section of website for our offerings. *Payment plans are also available for Multipass services.

CANCELLATION POLICY: Appointments cancelled less than 24 hours before start time may incur a 50% Cancellation Fee.

NO SHOW POLICY No showing for an appointment without the courtesy of contacting us in advance may incur a 100% No Show Fee.

I read and agree / will abide by the aforementioned clinic policies.

_____ _____

Client Signature Date