CELESTIAL WELLNESS - BARB FISCHER, RMT
CLIENT HISTORY AND INTAKE FORM
REFLEXOLOGY, REIKI, MASSAGE

Name: _____Occupation: _____Age: _____ D.O.B:_____

Address: _____ Phone number: _____

City: _____ Postal Code: _____ Cell: _____ Email address:_____

Are you insured for massage therapy? Yes/no Insurance Carrier (optional): _____

What benefits do you hope to gain through Reflexology, Reiki or Massage?_____

_____How did you hear about Celestial Wellness? _____

Is this your first Massage/Reflexology/Reiki treatment ?_____Do you receive Massage/Reflexology/Reiki on a regular basis? _____

Please explain any occupational health stresses (eg. Sitting too much, heavy lifting, etc): _____

Physical fitness routine stresses (eg. Swimming – shoulder difficulty, etc): _____
_____

Primary reason for visit: _____
_____
_____

Do you have frequent pain?_____ When did the pain start? _____ Describe the pain: _____
_____

What causes it? _____ What relieves it? _____

Are you taking any medication for this problem? _____

Name of Family Physician: _____ Phone number: _____

Are you seeing another practitioner (CHIROPRACTOR, PHYSIOTHERAPIST, ETC)?
_____
_____

SPECIAL NOTES: (PINS, WIRES, ARTIFICAL JOINTS OR LIMBS, SPECIAL EQUIPMENT – WHEELCHAIR, WALKER, CANE, ETC)
_____

IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, PLEASE EXPLAIN:

YES	**NO**	
___	___	Do you frequently suffer from stress? _____
___	___	Do you experience frequent headaches? Migraine / Tension? (Please circle which one)
___	___	Are you pregnant?
___	___	Are you Diabetic? If so, are you on oral medication or needle? _____
___	___	Do you have high / low blood pressure? Medication:_____
___	___	Are you on any medication? Medication: _____
___	___	Are you epileptic?
___	___	Have you had any recent surgeries? (PAST 5 YEARS) _____
___	___	Have you had any broken bones? _____
___	___	Have you had a spinal fusion? Describe: _____
___	___	Do you have any tension or soreness in a specific area? _____

YES **NO**

___ ___ Do you suffer from any back pain? Where? _____

___ ___ Do you have numbness or stabbing pains? Where? _____

___ ___ Are you sensitive to pressure / touch in any areas? _____

___ ___ Do you have any contagious health issues? _____

___ ___ Have you been in any Motor Vehicle accidents? When?_____

___ ___ Do you have any skin sensitivities or allergies (**nuts**, lanolin/wool, etc)? _____

___ ___ Do you or have you had any major illnesses (including cancer)? _____

___ ___ Do you have Asthma or any other lung conditions? _____

___ ___ Do you have HIV / Aids or Hepatitis? _____

___ ___ Do you have any other skin difficulties (herpes, shingles, athlete's foot, warts, acne, boils, open sores, edema, bruise easily, etc)?

_____

___ ___ Do you have any other cardiovascular difficulties (circulation, blood clots, thrombosis, aneurysm, blood pressure, mono, etc) ? Varicose veins, tingling/numbness, etc)?

_____

___ ___ Do you have any other muscular difficulties? (stiffness, weakness, swelling, range of motion, pain, strain, arthritis, etc)?

_____

___ ___ Do you have any other skeletal difficulties? (osteoporosis, fractures, disc difficulties, jaw pain, TMJ, whiplash, scoliosis, plantar fasciatis, etc)?

_____

___ ___ Do you have any other nervous system difficulties? (neuralgia, paralysis, headaches, dizziness, tension, fatigue, irritability, sleeping problems, severe emotional problems, etc)?

_____

___ ___ Do you have any other digestive difficulties? (Crohn's, IBS, diarrhea, constipation, ulcer, pancreatic, hepatitis, hernia, etc)?

_____

___ ___ Do you have any other respiratory difficulties? (pneumonia, shortness of breath, asthma, etc)?

_____

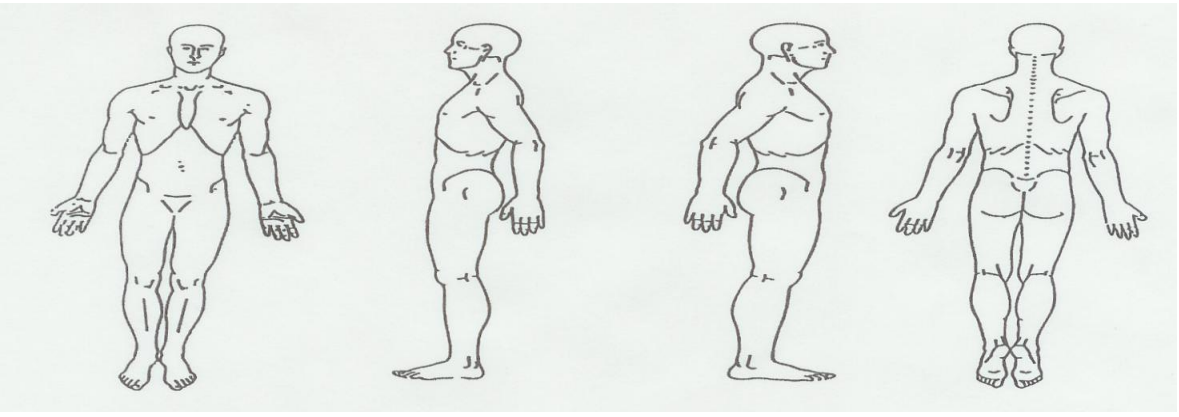
___ ___ Do you have any other reproductive or urinary difficulties? (kidney stones/disease, frequent urination, ovaries, prostrate, etc)?

_____

___ ___ Are you currently a smoker? Have you ever smoked for a lengthy period of time? _____

___ ___ Do you have any other medical conditions that I should be aware of? _____

ON THE DIAGRAMS, PLEASE INDICATE THE PROBLEM AREA(S):



Are there any areas that you preferred not to be worked on? _____

Please take a moment to carefully read the following information and sign where indicated:

TREATMENT
For the convenience of our clients, treatments are provided by Barb Fischer. All client information is strictly confidential. However, I give permission to Barb to discuss my treatments and share information for the purposes of my treatments.

I understand that the massage work I receive is provided for the basic purpose of relaxation and relief of muscular tension.

I 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 for the full scheduled appointment.

It may be necessary for the muscles of the gluteus area (buttocks) to be massaged. This will only be done with permission from the client. If I am uncomfortable with receiving massage treatment in the gluteus area I will discuss it with the practitioner prior to beginning the treatment or indicate below that I do not wish to receive treatment in this area.

I do not want to receive massage treatment in the gluteus area: _____

If I experience any pain or discomfort during the session, I will immediately inform the Therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

MEDICAL TREATMENT AND CONTRAINDICATIONS
I understand that any information provided in this form is used to assess my current complaint. I certify that all information collected here is true to the best of my knowledge.

I further understand that massage therapy (or other treatments provided) should not be construed as a substitute for a 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. I understand that Barb is 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 treatment given should be construed as such.

Because massage therapy (or other treatments provided) should not be undertaken for individuals with certain medical conditions, I affirm that I have stated all my medical conditions and answered all questions honestly. I agree to keep the practitioner updated to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

I agree to discuss with my family doctor or other medical practitioner whether these treatments are appropriate for me. If I have a medical condition of specific symptoms, massage work may be contraindicated. A referral from a physician may be required prior to services being provided.

I give permission to Barb to make available copies of all her records of my treatment to all appropriate parties needing them for legal, insurance or medical reasons.

PAYMENT
I understand that payment is due at the time services are provided. Receipts will be issued for third party insurance.

I understand that I may be billed for a missed appointment without 24 hours notice for cancellation.

SIGNED _____

PRINT NAME: _____ DATE: _____