

“To Promote Health & Restore Balance”

INSPIRED TOUCH LLC

Client Health Intake Form

Name _____ Date of Birth _____

Home Tn: _____ Cell # _____ E- Mail: _____

Street Address _____

City _____ State _____ Zip _____

Occupation _____

My job requires: Driving – Standing – Computers – Reaching – Sitting

How did you hear about us? _____

Have you ever received a professional Massage / Reflexology treatment? Yes No

How often? _____ Outcome? _____

How are you feeling today? (explain) _____

Check the appropriate box, if applicable:
I am a member of Connecticare “Healthy Alternatives” program _____
Please show us your member ID card to obtain your discount. Discounted fee is payable to Inspired Touch LLC at time of service. Member ID # _____

In the past 5 years, have you had any injuries / problems with any of following:

If yes, circle the conditions which apply.

Y N Joint problems/discomfort: arthritis, gout, hyper mobile joints _____

Y N Stress: job, home, illness, family, or other _____

Y N Bone: fracture, cancer, osteoporosis _____

Y N Headaches: Frequency _____ migraine, cluster, tension, PMS

Y N Circulatory: bruise easily, clots, varicose veins, phlebitis, arteriosclerosis

Y N Lymph: lymphoma, swollen glands, Lymphedema, cystic tissue _____

Y N Neurological: pinched nerves, sciatica, numbness or tingling in any area, stroke, epilepsy, or other _____

Y N Emotional difficulties _____

Y N Skin conditions: any current rash, severe acne, herpes, allergies, or other. _____

Y N Diabetes: Insulin dependent _____ or Oral medication only _____

Y N Surgery: Date & Reason _____

Y N Heart condition / High blood pressure (circle which)

Y N Muscle conditions: strains, sprains, trigger points, tear _____

Y N Any recent injury? _____

Y N Pregnant: due date _____ any related problems (explain) _____

Y N Food allergies / lotion /oil reactions: _____

Y N Cancer (please state type, duration and treatment) _____

Y N Are you wearing contact lenses? _____

Y N Any other medical conditions or concerns? _____

Are you currently taking any medications? No / Yes _____

Your Habits: Exercise _____ Tobacco use _____

Water intake / daily _____ Alcohol intake _____ Caffeine use _____

Sleep pattern _____ Bowel frequency _____

For Therapeutic Massage Clients only:

Is there any body area where you would like **extra time** spent? neck, shoulders, low back, upper back, etc. _____

Is there any area you prefer **NOT** to have touched? (face, feet, abdomen, etc.)
Where? _____

Does your physician know that you are receiving Massage/Reflexology Therapy? Yes No

If necessary, may we contact your doctor regarding your medical condition(s)? Yes No

Your Doctor's Name, Address & Phone _____

I understand that reflexology / massage therapy is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow. I understand that the therapist does not diagnose illness, does not prescribe or adjust medical treatment or drugs, nor do they perform any spinal manipulations. I understand that this therapy is not a substitute for traditional medical care and that it is recommended that I see a physician for any particular physical ailment I might have.

Client Signature _____ Today's Date _____

Inspired Touch LLC

CLIENT / THERAPIST BOUNDARIES

Appointment Time

- The Client will arrive at the appointed time. Client will give 24- hour minimum advance notice to reschedule or cancel an appointment.
- If client is late for an appointment, he/she will be treated for the remaining time of the session, and billed for the full session.
- A session can be lengthened based upon the Therapist's schedule.
- In the event of an emergency for either Client or Therapist, the session may be rescheduled based upon a mutual agreement.

Client / Therapist Confidentiality

- The Therapist does not share client information, unless requested in writing by the client. (E.g. Note to physician or insurance company)

Treatment

- The Client determines which areas not to treat. (i.e. feet or stomach).
- The Client will remain covered at all times and only the being worked on will be uncovered.
- The Client is encouraged to communicate the level of pressure or any discomfort to the Therapist.
- The Therapist does not talk to the Client during the session, unless to inquire about the level of pressure or discomfort.
- Treatment is provided in a specific designated space which is used solely for Massage / Reflexology services, where the Client's privacy is assured.
- An adult must accompany any person under the age of 18 years old during the session.
- No sexual intonation or behavior is tolerated.

Payment

- Payment is due at the time when service is rendered; cash, check, or gift certificates are accepted
- Returned checks will be assessed a \$40 fee.
- Gift certificates are paid in advance of service.

I (client) understand that this bodywork therapy is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation, improvement of circulation, and energy flow. I understand that the Therapist does not diagnose illness, disease or any other physical or mental disorder. The Therapist does not prescribe pharmaceuticals or perform any type of spinal manipulations. It has been made clear that this therapy is not a substitute for traditional medical care and it is recommended that I see a physician for any physical ailment that I might have.

We, Client and Therapist, agree to adhere to the specified boundaries. If for some reason the Client cannot adhere to these Boundaries, the Therapist will discuss a course of action which may result in a Right to Refuse treatment to the Client.

Signature (Client) _____ Date _____

Signature (Therapist) _____ Date _____