INNOVAETAS, LLC
Therapeutic massage and bodywork for Innovative Aging

HEALTH INTAKE FORM- CONFIDENTIAL INFORMATION

FIRST NAME: _____ LAST NAME: _____
ADDRESS: _____
CELL PHONE: _____TEXT ME (circle one): YES or NO
EMAIL: _____EMAIL ME: (circle one): YES or NO
OCCUPATION: _____ DATE OF BIRTH: _____

HAVE YOU EVER RECEIVED THERAPEUTIC BODYWORK? (circle one): YES or NO
TYPE OF BODYWORK RECEIVED (Massage, Energy Healing, etc.): _____
_____

ARE YOU CURRENTLY SEEING A HEALTHCARE PROFESSIONAL? (circle one): YES or NO
IF YES, PLEASE LIST DIAGNOSIS, AND DESCRIBE TREATMENTS, MEDICATIONS, ETC. _____
_____
_____

PLEASE LIST ALL SURGERIES: (Surgery leads to the formation of scar tissue and myofascial adhesions, both of which can cause substantial pain and stress. For best results, be as thorough as possible): _____
_____
_____
_____

PLEASE REVIEW THE LIST BELOW AND INDICATE ANY THAT HAVE AFFECTED YOUR HEALTH WITH A CHECK MARK:

_____ ACNE _____ALLERGIES _____ANEMIA _____ANXIETY _____ARTHRITIS _____ASTHMA _____BELL PALSY

_____BLOOD CLOTS _____BROKEN/DISLOCATED BONES _____BRUISE EASILY _____CANCER _____CHRONIC PAIN

_____COMMUNICABLE DISEASE _____DIABETES _____DIGESTIVE DISORDERS _____ENDOCRINE DISORDERS

_____FIBROMYALGIA _____FUNGAL INFECTION _____HEADACHES _____HEART CONDITIONS _____HERNIA

_____HERNIATED DISC _____HIGH/LOW BLOOD PRESSURE _____HIVES _____HYPO/HYPERGLYCEMIA _____IBS

_____INSOMNIA _____MASTITIS _____MENTAL DISORDER _____MULTIPLE SCLEROSIS _____MYOFASCIAL PAIN

_____OSTEOPOROSIS _____PARESTHESIA _____PARKINSON DISEASE _____PREGNANCY _____ROSACEA

_____SCOLIOSIS _____SEIZURE DISORDER _____SHINGLES _____SKIN CONDITIONS _____SPRAIN/STRAIN

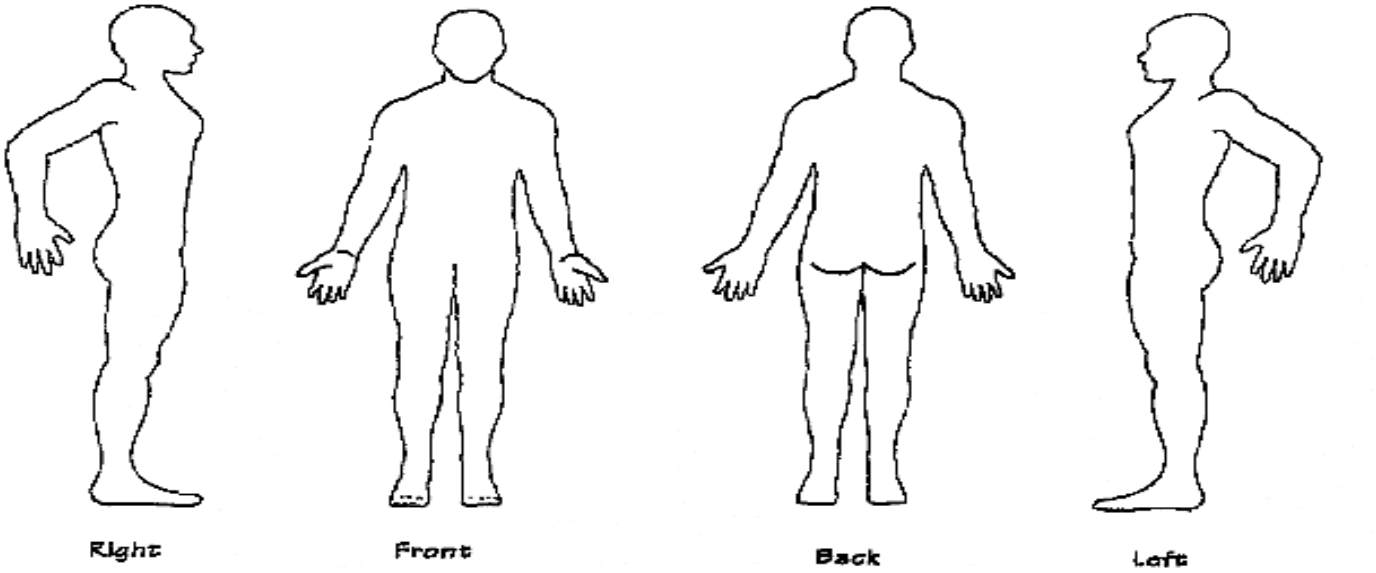
_____STROKE _____TMJD _____TOS _____TORTICOLLIS _____TUMOR _____WART _____WHIPLASH

DATE(S) (OR AGE) OF ABOVE PATHOLOGY AND PROGNOSIS: _____
_____
_____
_____
_____

HEALTH INTAKE FORM- CONFIDENTIAL INFORMATION (continued)

DO YOU HAVE ANY OF THE FOLLOWING TODAY:
_____SKIN RASH _____COLD/FLU _____OPEN CUTS/SORES (include bug bites and scratches)
_____SEVERE PAIN _____ANYTHING CONTAGIOUS _____INJURIES/BRUISES

ON THE DIAGRAM BELOW:
PLEASE **CIRCLE** AREAS OF CHRONIC DISCOMFORT YOU WOULD LIKE ME TO FOCUS ON FOR TREATMENT
PLEASE INDICATE WITH AN **X** ANY AREAS OF ACUTE PAIN



WHAT ARE YOUR GOALS FOR A TREATMENT PLAN (I understand it will likely take more than one session):
_____
_____
_____

The following sometimes occur during Myofascial Release / Reiki / Therapeutic Massage sessions.
Trust your body to express what it needs, and allow:
Sighing, yawning, changes in breathing **<>** falling asleep **<>** memories **<>** energy shifts
emotional feelings and/or expression **<>** the need to move or change positions
temperature changes **<>** stomach gurgling **<>** movement of intestinal gas

Please read the following information and sign below:

1. I understand that Myofascial Release/ Reiki / Therapeutic Massage can be therapeutic, reduce stress, reduce muscular strain, pain, scar tissue, etc. It is not a substitute for medical examination, diagnosis, and medical treatment.
2. Being that Myofascial Release / Reiki / Therapeutic Massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

SIGNATURE: _____ DATE: _____

CONSENT TO TREAT AND WAIVER:

PLEASE TAKE A MOMENT TO READ AND INITIAL ALL OF THE FOLLOWING STATEMENTS:

_____ If I experience pain or discomfort during the session I will immediately inform my therapist so that pressure, the temperature of the table, position of the face cradle and/or bolstering can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort.

_____ I understand that the services offered today are not a substitute for medical care, and are intended as a complement to any medical treatment I am currently receiving. I understand that my therapist will not perform any skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

_____ I affirm that I have notified my therapist of all known medical conditions and injuries.

_____ I agree to inform my therapist of any changed in my health and medical conditions. I understand that there shall be no liability on the therapist's part should I fail to do so.

_____ I understand that treatments offered by Hilton Head Holistic Healing, LLC are purely therapeutic and non-sexual in nature. Treatment sessions will be terminated in the case of any inappropriate or threatening actions.

_____ By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to treatments.

_____ I understand that should I cancel an appointment less than 24 hours before the scheduled time or miss an appointment without sufficient notice I am subject to a fee equal to the cost of the missed appointment. If I have purchased a package of treatments, one of the pre-paid sessions will be used to cover the missed session.

INFORMATION AND SUGGESTIONS:

1. Please remove all jewelry and pull up long hair in a high ponytail.
2. You may be more comfortable and better able to relax if you remove contact lenses and/or hearing aids.
3. You will be covered and draped with a top sheet modestly and respectfully throughout the massage, but please undress only to your comfort level, and ask your therapist if you have any questions.
4. Feel free to ask your therapist any questions before, during, or after the session. But, don't feel that you have to speak during the session. It is perfectly acceptable to quietly doze off and enjoy the treatment.

I HAVE RECEIVED AND REVIEWED THE POLICY STATEMENT, AND I HAVE READ AND AGREE TO THE ABOVE POLICIES:

CLIENT NAME (print): _____
CLIENT NAME (signature): _____
DATE: _____

THERAPIST SIGNATURE: _____