CLIENT INTAKE FORM

Name: ____________________ Phone: ____________ Birthday: __________
Address: ____________________ City: ____________ State: ______ Zip: ________
Your Occupation: ______________ Email: ______________________

Can we add you to our email list for appointment and event updates? **Yes No**

What was your *favorite* part of the last massage you received? What was your *least favorite*? *(This helps us!)*

____

Referred by: ______________ Emergency Contact info: ____________________

Are you currently being treated by a physician for any condition? **Yes No**
Do we have your permission to contact your physician should the need arise? **Yes No**
Physician: ____________________ Contact info: ____________________

PLEASE CIRCLE ALL SYMPTOMS AND CONDITIONS EVER EXPERIENCED IN YOUR WHOLE LIFE:

Circulatory

Blood Clots *or Blood Thinning Meds*
Phlebitis / Varicose Veins
Heart Conditions
Stents/Shunts or Pacemaker
Low or High Blood Pressure
Lymphatic issues / Edema
Circulation Issues
High Cholesterol

Digestive

Constipation / IBS
Ulcer
Low Blood Sugar/ Hypoglycemia
Diabetes

Musculoskeletal

Muscle pain or weakness
Neck Injury or Whiplash
Foot issues:
Plantar Fasciitis, bunion, neuroma, pins
Joints:
Stiffness, pain, dislocation, replacement, surgery, joint disease, pins, plates
Broken Bones
Osteoporosis / Osteopenia
Tendonitis / Bursitis
Arthritis / Gout / Lupus
Jaw Pain / TMJD
Spine issue:
Coccyx injury, Scoliosis, Spondylolethesis, Spondylitis, Stenosis, Degenerative Disc Disease, Laminectomy, Herniated or Bulging disc, Spinal Rods / Fusions / Screws / Cages, etc)
Carpel Tunnel

Respiratory

Respiratory Illness
Allergies *(Please list all)*
Sinus Congestion

Nervous System

Neurological Condition
(Sciatica, Numbness, decreased sensation, loss of motor control, shooting pain, tingling)
Stroke
Epilepsy, Seizures, Fainting
Stress Level: *High / Medium / Low*

Skin

Skin Disorders
Psoriasis, plantar warts, athletes foot , cellulitis, infection, etc
Contagious Diseases
Rashes, Topical/Nut Allergies

Reproductive

Pregnant, nursing or trying to conceive

Other

Cancer
Surgeries *please list all in the column>>*
Augmentation / Implants
(Breast, Gluteal, cheeks, lips, Calf, etc)
Thyroid, Bladder, Kidney or Liver Issue
Headaches or Migraines
Abdominal Hernia
Auto Immune Illness
Dizziness or Vertigo
Eye / Optical issues
(eye strain, optical nerve issues, recent Lasik surgery, wearing contacts)
HIV +
Injections / Shots
(Cortisone, Epidural Steroid Injections, Nerve Blocks, Trigger Point Injection, Flu shot, Botox, Depoprovera, etc)

Other:

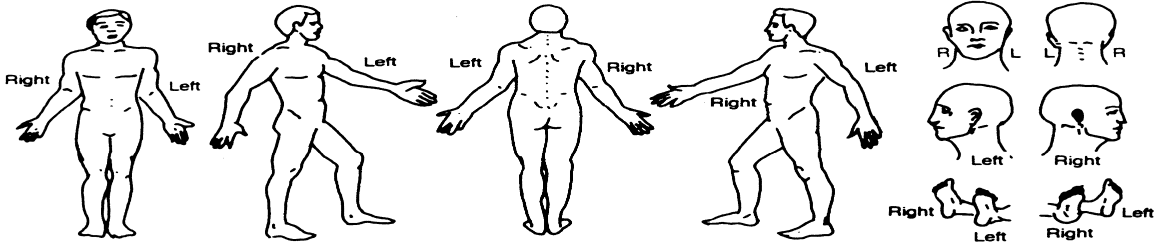
PLEASE EXPLAIN ANYTHING CIRCLED OR NOT LISTED

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS

PLEASE CIRCLE YOUR PREFERRED TYPE OF MASSAGE THERAPY

Ashiatsu *(Deep Tissue)* **Ashi-Thai** *(Passive Stretching)* **Ashi-Anma** *(Medium Pressure with Rocking Movements)*
Pada Mudra *(Foot Massage / Reflexology)*

PLEASE CIRCLE AREAS OF YOUR MAIN CONCERN FOR TODAY'S MASSAGE (DRAW WHERE IT HURTS!)



What is your goal for today's appointment and following sessions?

____

PLEASE READ AND AFFIRM BY INITIALING

____ I understand that breast massage will not be performed during my treatment.

____ I understand that complete draping with a sheet will be used throughout my session.

____ It is my responsibility to voice any concerns to my therapist immediately if pressure, pain, temperature sensitivities or any other comfort issues arise during my session.

THERAPEUTIC AGREEMENT

I understand that the massage given here is for the purpose of promoting: holistic wellbeing, natural structural balance, pain reduction, relief of muscular tension or spasm, stress reduction, and increased circulation.

I understand that the therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulation. I understand the services are designed to be a health aid and are in no way to take the place of doctor's care when it is indicated. Information exchanged during any sessions is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

Because a therapist must be aware of existing and past physical conditions in order to perform this advanced massage technique, I have stated ALL of my health conditions, symptoms and "tissue issues", and I will take it upon myself to keep the therapist updated throughout our professional relationship.

I will indicate to the therapist anything that makes me feel uncomfortable. I understand that either I, or the therapist, have the right to terminate a session at any time.

Client Signature: ____ Date: ______________

Massage Therapist Signature: __________________________________ Date: _____________

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POLICIES & FEES

Cancellation

A credit card is always required to reserve an appointment with Heeling Sole. We do not charge this card except for when our Cancellation Policy needs to be applied. Due to the high demand of our services, we require 24 hours prior to your allotted time for appointment changes and/or cancellations. For changed or cancelled appointments within 24 hours of their scheduled start time, you may be charged 50% of the regular price, for missed appointments without notice, the full price of the session may be charged to your account.

Appointment time

Your appointment is reserved for you, and only you. Arriving late may possibly interfere with your treatment time so as not to affect the appointment after yours. Sessions will incorporate as much “massage time” as possible, however, your session may require 5 minutes of pre-session interviewing, post-session follow-up and/or self-care suggestions to better enhance your massage experience.

Payment / Refunds / Offers / GiftCards

Payment is due at the end of each session. We do not participate in any medical insurance plans. A $25.00 fee will be charged for checks returned by the bank.

All sales (gift certificates, series packages, prepaid massage, classes, and/or any services offered) are final and non-refundable. However, they are transferrable and may be gifted to another person for any reason.

Offers cannot be combined.

GiftCards for flat dollar amounts do not expire; we request that they be redeemed within a year from the purchase date. There will be a $5 deduction to the GiftCard on the day after its year anniversary if it maintains an unused balance. GiftCards for specified services may be limited time offers, so please check the fine print of each gift card.

Prices for Sessions

$40 for 30 minutes, $80 for 1 hour, $120 for 90 minutes, $160 for 2 hours
Sessions with Jeni Spring are $45/30 minutes, $90/60 minutes, $135/90 minutes, & $180/2 hours.

Professionalism:

We have a strict policy regarding the mutual professionalism and level of respect maintained here at Heeling Sole. Any inappropriate requests, behaviors or actions from clients will result in a termination of the session, and your account will be charged the full amount of the session. Heeling Sole reserves the right to refuse service to anyone, be it for reasons of personal safety, issues of health or hygiene, or for requests that are outside of a Massage Therapists scope of practice.

I HAVE READ THE ABOVE POLICIES AND UNDERSTAND THEM CLEARLY.

Signature ____ Date: ________________

CONSENT FOR TREATMENT OF A MINOR

Our deep, aggressive compression massage technique is best suited for those over the age of 18. Our exception is for teen athletes, and we limit the sessions to only 30-60 minutes. A guardian must be present during the session. By my signature below I hereby authorize the Massage Therapist to administer body therapy to my child or dependent, as they deem necessary.

Signature of Parent or Guardian: ___________________________________ *Date:* _______________