Client Intake Form

Name_____ Date of Birth_____

Street Address_____City_____State_____Zip_____

Phone (cell)_____Phone (home)_____

Email Address _____ Occupation _____

Emergency Contact _____Relation _____ Phone_____

How did you hear about us? (Please circle all that apply) web, social media, friend, family, professional/provider

Who Referred you?_____ May we thank them? Y◯ N◯

To insure your satisfaction, please describe your expectations for today's visit.

Please specify specific body areas needing attention.

List current medications.

List any surgeries, broken bones, or major car accidents.

Do you currently have any of the following?

Y◯ N◯ Heart Condition

Y◯ N◯ Diabetes

Y◯ N◯ Allergies(describe)
_____

Y◯N◯Skin Conditions (describe)
_____

Y◯N◯Recurring Headaches (describe)
_____

Y◯N◯Swelling in legs, hands, or feet

Y◯N◯High/ Low Blood Pressure.
If yes, is it regulated by medication?

Y◯N◯Sensitivities to oils, lotions, or scents

Y◯N◯Are you experiencing or being treated for depression or anxiety?

Y◯N◯Are you being treated for any other emotional/ psychological condition?

Y◯N◯Are you currently under a physician's care?

Y◯N◯Are you pregnant, postpartum or nursing? If yes, please complete the questions on the back of this page.

Y◯N◯Are you experiencing any menstrual or
Y◯N◯menopausal symptoms today?

Is this your first massage? Y◯ N◯

List stress reduction and exercise activities, including frequency.

Anything else you feel we should know?

***Please Read and Sign our Client/Therapist Agreement on the Back of this page.**

Client Intake Form

If you are Pregnant, Postpartum, or Nursing, please complete the following questions:

Today I am: ☐ Pregnant ☐ Postpartum ☐ Breastfeeding

How many weeks pregnant or postpartum are you today? _____

What is your estimated due date or what was baby's birth date? _____

Is this your first pre-natal or postpartum massage? Y◯ N◯

How many times have you been pregnant?

Do you have a history of miscarriage? Y◯ N◯

Did you use fertility treatments to aid in conception? Y◯ N◯

If yes, please explain:

Describe any complications you have experienced with this pregnancy:

Describe any complications you had in past pregnancies:

Have you been diagnosed with gestational diabetes? Y◯ N◯

Do you have a history of phlebitis(inflammation or swelling of a vein)? Y◯ N◯

Do you have a history of deep vein thrombosis? Y◯ N◯

Have you experienced depression with this pregnancy or postpartum period? Y◯ N◯

Please check any of the following that you have experienced during this pregnancy or postpartum:

☐ Acid Indigestion	☐ Varicosities/Hemorrhoids	☐ Sciatica	☐ Anxiety
☐ Incontinence	☐ Round or Broad Ligament Pain	☐ Carpal Tunnel Syndrome	☐ Nausea and/or vomiting
☐ Constipation/diarrhea	☐ Shortness of breath	☐ Cesarean Scaring	☐ Fatigue
☐ Swelling	☐ Birth Trauma	☐ Muscle cramps	☐ Trouble sleeping
☐ Diastasis Recti	☐ Mastitis/Engorgement/Plugged duct	☐ Prolapse	☐ Vaginal/Perineal Tear

☐ Other, please explain_____

The Womb Wellness Center 24 Hour Cancelation Policy:

24 hour advance notice is required when canceling or rescheduling your appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours notice you will be responsible for paying the full amount of your appointment fee.

Please initial your understanding of this policy_____

Please read and sign our Client/ Therapist Agreement

I realize massage/bodywork is primarily for relaxation and stress relief. I understand that any information offered by the therapist is for educational purposes only, and in no manner should be construed as a diagnosis of any kind. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. If I experience any pain or discomfort, I will immediately inform the therapist so the pressure or methods can be adjusted to my comfort level. Because massage/ bodywork should not be performed under certain circumstances, I agree to notify the therapist in writing of any changes in the medical information I have provided today.

Signature _____ **Date** _____

COVID19 Safety Form

Additional Health Questions:

- Have you had a fever in the last 24 hours of 100°F or above? Y/N
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, cough, or shortness of breath? Y/N
- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Y/N

Modified Cancelation Policy

24-hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24-hours advance notice you will be charged the full amount of your appointment. *If you are experiencing respiratory or flu like symptoms including, fever, cough, or shortness of breath you must reschedule your appointment and you will not be charged the cancellation fee. Please give us as much notification as possible.*

I understand that if at anytime in the future I reply yes to any of the above health questions prior to my appointment in the studio I must call to reschedule my appointment. _____ initial

Consent

I understand that, because acupuncture and massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive acupuncture and/or massage from a practitioner at The Womb Wellness Center.

Client Name _____

Signature _____

Date_____