Reconnect 2 Self
Healing Arts

NEW CLIENT INTAKE FORM

First and Last Name: _____

Date of birth: _____ **Phone/Email**: _____

Street address: _____

City, state, zip:_____

Referred by: _____

Emergency contact name/phone: _____

Occupation: _____

Physician/Healthcare provider's name and phone number:
_____

What do you hope to get from today's session?_____

_____

List any medications you currently take: _____

List any surgeries and approximate dates including any lymph node removal.

_____

_____

List any skin allergies or sensitivities to scents:

_____

Please list any current or past medical conditions we need to be aware of:

_____

_____

Please let us know of any areas of your body that you DO NOT want touched:

_____

Have you received this bodywork before? _____

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are 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 the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also 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 of the scheduled appointment.

I understand that Reconnect 2 Self, LLC requires a 24 hour notice to cancel or reschedule sessions. Session payment is required in full if I cancel with less than 24 hours notice except in the case of an emergency.

Understanding all of this, I give my consent to receive care.

Client Name Printed: _____

Client Signature _____

Date _____