Gaealana Healing Arts Center

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(503)564-0179

Client Intake Form

Name:_____Date:_____

Referred by:_____

Address:_____

Phone:_____ Birthday:_____

Occupation:_____ E-mail:_____

Emergency Contact:_____ Phone:_____

Have you received massage therapy before?_____If so what type?_____

Would you like to receive our monthly e-newsletter with special offers? __yes ___no

Please mark past (p) or current (c) conditions which apply to you:

__Low Blood Pressure
__Athlete's Foot
__TMJ Disorder
__Indigestion
__Fibromyalgia
__Varicose Veins
__Constipation
__Plantar Fascitis

__Numbness
__Stroke
__Arthritis
__Fatigue
__Diabetes
__Asthma
__Heart Disease
__Depression
__Stiffness

__Skin disorders
__Communicable Diseases
__Osteoarthritis
__PMS Syndrome
__Sleep Disorders
__Dizziness
__High Blood Pressure
__Compromised Immunity
__ PTSD

__Allergies
__Spinal Injury
__Bursitis
__Headaches
__Broken Bone
__Sciatica
__Cancer
__Anxiety

Are you currently under a physician's care? For what? Please explain any current health problems.

Please list any surgeries, accidents or major illnesses in the last two years.

Are you taking any medications, vitamins, or supplements?

What are the primary sources of stress in your life? Where in your body to you hold stress?

What do you do to relax? What do you do to exercise?

What are your current goals for massage?

Informed Consent and Business Agreement

Full Payment is due at the time of treatment. A cancellation must be made 24 hours in advance to avoid charges. You are responsible for half the cost of an appointment cancelled within 24 hours and full price of an appointment missed without cancellation. Payments must be made before receiving further treatment. In the case that you are using health or auto insurance to pay for a portion of your care in this office, an arrangement may be made to omit payment and await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to 6 months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize my provider,____ _____, to release my medical records relating to claim for benefits submitted.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I hereby give my consent to receive therapeutic massage.

Signature:_____Date:_____