THE WELLNESS CENTER

REGISTRATION AND HEALTH INTAKE FORM

1 CLIENT INFORMATION

Date _____

Client _____

Address _____

_____
City State Zip

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Partnered

Occupation _____

Employer _____

Spouse's Name _____

Occupation _____

Spouse's Employer _____

How did you find us? _____

IN CASE OF EMERGENCY, CONTACT

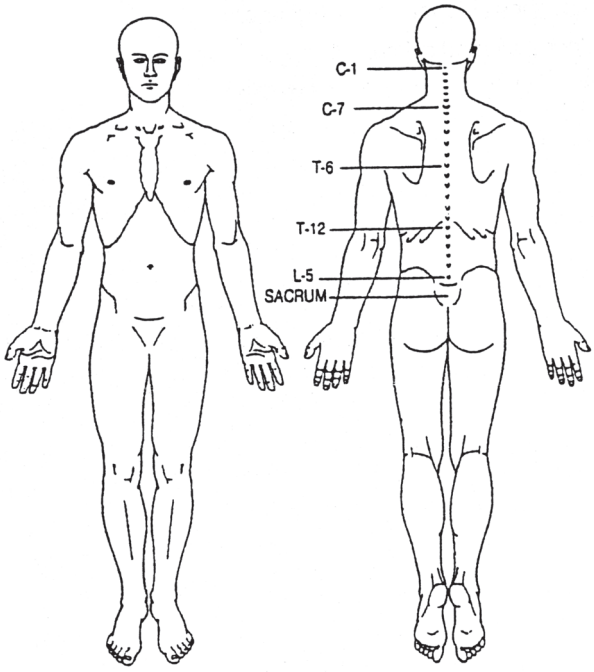
Name _____ Relationship _____

Home Phone _____

Work Phone _____

2 PAIN QUESTIONNAIRE

PLEASE INDICATE WITH AN (X - or CIRCLE),
THE PLACES YOU ARE FEELING DISCOMFORT



3 CONTACT INFORMATION

Home Phone _____

Work Phone _____ Ext _____

Cell Phone _____

Best time and place to reach you _____

E-mail address _____

4 CURRENT CONDITION

DO YOU HAVE ANY OF THE FOLLOWING TODAY:

❑ sunburn	❑ open cuts, bruises, burns
❑ inflammation	❑ irritated skin rash
❑ severe pain	❑ poison ivy
❑ headache	❑ cold/flu

Are You: ❑ Right Handed or ❑ Left Handed

5 MASSAGE HISTORY

Have you ever received a professional massage? ❑ Yes ❑ No

Type of massage experienced: ❑ Deep Tissue ❑ Swedish ❑ Other _____

Why did you come for our service? ❑ Relaxation ❑ Pain ❑ Therapy ❑ Other _____

What results would you like to achieve? _____

Please note any areas of your body that you **prefer not to be** massaged._____

_____

— TO REVERSE SIDE —

6 HEALTH HISTORY

Please check ☑ conditions or symptoms you currently have or have had in the past:

❑ Anemia	❑ Cancer	❑ Hernia	❑ Pacemaker	❑ Stroke
❑ Anorexia	❑ Chemical Dependency	❑ Herniated Disk	❑ Parkinson's Disease	❑ Tendonitis
❑ Appendicitis	❑ Diabetes	❑ Herpes	❑ Pinched Nerve	❑ Thyroid Problems
❑ Arthritis	❑ Emphysema	❑ High Blood Pressure	❑ Pneumonia	❑ Tuberculosis
❑ Asthma	❑ Epilepsy	❑ Jaw Pain/TMJ	❑ Polio	❑ Tumors, Growths
❑ Blood Clots	❑ Fractures	❑ Lymphedema	❑ Prosthesis	❑ Ulcers
❑ Breathing Difficulty	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Varicose Veins
❑ Bursitis	❑ Head Injuries	❑ Mononucleosis	❑ Rheumatoid Arthritis	❑ Whiplash
❑ Bronchitis	❑ Heart Disease	❑ Multiple Sclerosis	❑ Rheumatic Fever	❑ Other _____
❑ Bulimia	❑ Hepatitis	❑ Osteoporosis	❑ Sinus Problems	_____

MEDICATIONS

Medication _____ Taking For _____

_____ _____

ALLERGIES

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

EXERCISE

❑ None ❑ Daily

❑ Moderate ❑ Heavy

WORK ACTIVITY

❑ Sitting ❑ Light Labor

❑ Standing ❑ Heavy Labor

LIFESTYLE

❑ Smoking Packs/Day_____ ❑ Coffee/Caffeine Cups/Day_____

❑ Alcohol Drinks/Week ____ ❑ High Stress Level Reason_____

Are you pregnant? ❑ Yes ❑ No ❑ Due Date _____

Letter of Prescription Attached ❑ Yes ❑ No ❑ On file

Please list any medical conditions, surgeries accidents, and bone, joint or muscle diseases or injuries not specified above.

_____ _____ _____ _____

Date Date

7 FLOAT TANK INFORMATION AND RELEASE FORM

Do not float today if you have any of the following conditions:

❑ A cold or flu ❑ Incontinence, flatulence or hemorrhoids ❑ Any infectious disease

❑ Menstrual period or yeast infection ❑ Open sores, cuts, rashes, or skin problems ❑ Sunburns or burns

Do you wear contact lenses? _____ If so, you should remove prior to floating.

Have you used a float tank previously? _____ If so, where? _____

What interests you in floating? _____

Where did you hear about the Wellness Center and/or Floating Therapy? _____

_____

WAIVER OF LIABILITY: I understand that the floatation therapy offered here is for the purpose of stress reduction, relaxation, and self-enhancement. Although there are studies indicating that floatation thereapy can reduce and/or relieve various physical and psychological symptoms, I realize that I should consult my doctor and/or therapist in these regards.

Furthermore, I release the Wellness Center, its owners, heirs, staff and affiliates from all responsibility and any legal recompense if I should become injured, experience physical or psychological distress of any kind that may incur a loss at the Wellness Center and/or prior to, during or after floating.

_____ _____

Signature Date

8 AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status.

I hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me.

I understand that massage therapy services are designed to be health aid and are in no way a substitute for a doctor's care.

Information exchanged during massage sessions is educational in nature and is to be used at my own discretion.

I am responsible for paying for any appointment cancellation of less than 24 hours.

_____ _____

Signature Date

9 NOTICE OF PRIVACY

Acknowledgement of Receipt of the Notice of Privacy Practices and the Health Care Freedom of Access Act, Chapter No. 460-House File 3839.

The Wellness Center seeks proof that clients/patients have received and/or reviewed the Notice of Privacy Practices and the Freedom of Access Act for non-licensed practitioners. My signature below indicates only that I have received a copy of the Wellness Center's Privacy Practices and the Freedom of Access Act, not that I have read it or agree with its contents.

_____ _____

Signature of patient Date