Heather Maxwell
5055 Marathon Dr.
Madison, WI 53705
608-233-8569

# Intake Form

Name _____ Date of Birth _____ Today's Date _____

Address (include Street, City, Zip) _____

Email _____

Home Phone _____ Cell Phone _____

Occupation _____ Insurance _____

Emergency Contact: Name _____ Phone _____

Have you ever had professional massage or bodywork? yes no

## Health History [Check all that you currently have or have had recently]

- ❍ Dentures
- ❍ Contacts
- ❍ Frequent stress
- ❍ Depression
- ❍ Muscle cramping
- ❍ Muscle spasms in neck/back
- ❍ Tightness in shoulder muscles
- ❍ Sacroiliac or low back pain
- ❍ Back pain
- ❍ Herniated disk(s)
- ❍ Rotator cuff injury
- ❍ Plantar fascitis
- ❍ Tingling in arms, hands, legs
- ❍ Carpal tunnel
- ❍ Allergies _____
- ❍ Headaches
- ❍ High/Low Blood Pressure
- ❍ Dizziness or fainting
- ❍ Sinus trouble
- ❍ Osteoarthritis
- ❍ Rheumatoid arthritis
- ❍ Swollen or painful joints
- ❍ Circulatory/ Heart Problems
- ❍ Varicose Veins
- ❍ Phlebitis/blood clots
- ❍ Open sores/ulcerations
- ❍ Blood Clotting Disorder
- ❍ Scoliosis
- ❍ Asthma
- ❍ Current smoker
- ❍ Shortness of breath
- ❍ Thyroid trouble
- ❍ Liver trouble
- ❍ Gall bladder trouble
- ❍ Stomach trouble/ulcers
- ❍ Indigestion
- ❍ Kidney trouble
- ❍ Stroke
- ❍ Dermatitis
- ❍ Diabetes Type _____
- ❍ Eczema
- ❍ Epilepsy
- ❍ Currently Pregnant
- ❍ Serious accidents/ whiplash injury
- ❍ Broken bones
- ❍ Current contagious disease
- ❍ Current or past cancer
- ❍ Surgeries _____

_____

## Medications

_____

_____

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# Informed Consent Statement

- I understand that massage/bodywork professionals do not diagnose illness or disease; do not prescribe medications or medical treatments; and do not perform spinal manipulations.
- I understand that massage therapy is not a substitute for medical examination or diagnosis and that I should see a physician for these services.
- I understand and agree to disclose and update all of my known medical conditions because there are circumstances under which massage/bodywork should not be performed. I release the massage professional from any liability if I fail to do this.
- I understand that the therapist needs to be aware of any existing physical conditions and medications; therefore I have stated all of my known medical conditions and take it upon myself to keep the therapist updated on my physical health.
- I understand that the client therapist relationship will be held in strict confidence.
- I understand that I may discontinue my massage at any time.
- 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 comfort level.
- I understand that any illicit or sexually suggestive behavior, remarks, or advances will result in immediate termination of the session and I will be liable for the scheduled appointment.
- I give permission for Create Thrive Grow to share information about my visits, including Intake Forms and progress reports, with the following parties: my prescribing physician, my insurance company, and in case of litigation, my attorney.
- **PAYMENT:** I understand that I am responsible for entire payment at the time of service. Payments may be made by cash or personal check.
- **REMEMBERING APPOINTMENTS:** I understand that it is my responsibility to remember appointments that I have scheduled. I understand that my therapist may provide a reminder call or email, but that with or without this reminder, it is ultimately my responsibility to remember my appointments. I understand that if I forget an appointment, I am still responsible for payment.
- **CANCELLATION:** I understand that if I need to cancel or reschedule an appointment, I will give at least 48 hours notice. I understand that I will be charged for the appointment unless I can make arrangements for someone else to fill my appointment time. Emergency cancellations are determined at therapist's discretion.
- **TIMELINESS**: I understand that it is my responsibility to arrive on time. Sessions begin and end at scheduled times. Sessions begun late due to the client arriving late end at the appointed time and are full price.
- **MAILING LIST:** I understand that I may receive periodic inspirational emails and offers from Create Thrive Grow. My email address will not be sold. I can opt out of mailings at any time.

Signature _____

Printed Name _____ Date _____

Parent/Guardian signature if client is under 18 years of age _____