

# élan Healing Arts

## Client Information

<b>Name</b>	<b>Street</b>		
	<b>City</b> <span style="margin-left: 150px;"><b>St</b></span> <span style="margin-left: 50px;"><b>Zip</b></span>		
<b>Phone</b>	<b>e.mail</b>		
<b>Date of Birth</b>	<b>Employer</b>		
<b>Date of last session</b>	<b>Referred by</b>		
<b>In case of emergency contact</b>			
<b>Name:</b>	<b>Relationship:</b> <span style="margin-left: 150px;"><b>Phone:</b></span>		
<p>Please <b>X</b> all conditions that apply to you – note specifics on additional lines.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Stress  <input type="radio"/> Back pain  <input type="radio"/> Diabetes  <input type="radio"/> Pregnant  <input type="radio"/> Arthritis  <input type="radio"/> Epilepsy or seizures  <input type="radio"/> Joint swelling  <input type="radio"/> Athletes feet  <input type="radio"/> Osteoporosis  <input type="radio"/> Allergies  <input type="radio"/> Bruise easily  <input type="radio"/> Varicose veins  <input type="radio"/> Cardiac problems  <input type="radio"/> Depression         </td> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Frequent headaches – headache today yes / no  <input type="radio"/> Numbness or stabbing pain (indicate location below)  <input type="radio"/> High blood pressure – on medication yes / no  <input type="radio"/> Contagious disease _____  <input type="radio"/> Accident/injuries leaving you in pain _____  <input type="radio"/> Tension/swelling/soreness in a specific area _____  <input type="radio"/> Circulatory problems  <input type="radio"/> Warts/moles  <input type="radio"/> Open sores/cuts  <input type="radio"/> Prior hospitalizations: _____  <input type="radio"/> Note any other medical conditions/medications therapist should be aware of:            _____            _____         </td> </tr> </table>		<input type="radio"/> Stress <input type="radio"/> Back pain <input type="radio"/> Diabetes <input type="radio"/> Pregnant <input type="radio"/> Arthritis <input type="radio"/> Epilepsy or seizures <input type="radio"/> Joint swelling <input type="radio"/> Athletes feet <input type="radio"/> Osteoporosis <input type="radio"/> Allergies <input type="radio"/> Bruise easily <input type="radio"/> Varicose veins <input type="radio"/> Cardiac problems <input type="radio"/> Depression	<input type="radio"/> Frequent headaches – headache today yes / no <input type="radio"/> Numbness or stabbing pain (indicate location below) <input type="radio"/> High blood pressure – on medication yes / no <input type="radio"/> Contagious disease _____ <input type="radio"/> Accident/injuries leaving you in pain _____ <input type="radio"/> Tension/swelling/soreness in a specific area _____ <input type="radio"/> Circulatory problems <input type="radio"/> Warts/moles <input type="radio"/> Open sores/cuts <input type="radio"/> Prior hospitalizations: _____ <input type="radio"/> Note any other medical conditions/medications therapist should be aware of: _____ _____
<input type="radio"/> Stress <input type="radio"/> Back pain <input type="radio"/> Diabetes <input type="radio"/> Pregnant <input type="radio"/> Arthritis <input type="radio"/> Epilepsy or seizures <input type="radio"/> Joint swelling <input type="radio"/> Athletes feet <input type="radio"/> Osteoporosis <input type="radio"/> Allergies <input type="radio"/> Bruise easily <input type="radio"/> Varicose veins <input type="radio"/> Cardiac problems <input type="radio"/> Depression	<input type="radio"/> Frequent headaches – headache today yes / no <input type="radio"/> Numbness or stabbing pain (indicate location below) <input type="radio"/> High blood pressure – on medication yes / no <input type="radio"/> Contagious disease _____ <input type="radio"/> Accident/injuries leaving you in pain _____ <input type="radio"/> Tension/swelling/soreness in a specific area _____ <input type="radio"/> Circulatory problems <input type="radio"/> Warts/moles <input type="radio"/> Open sores/cuts <input type="radio"/> Prior hospitalizations: _____ <input type="radio"/> Note any other medical conditions/medications therapist should be aware of: _____ _____		
<p><i>I understand that bodywork (including, but not limited to: massage, gua sha, reflexology, acupressure, dry brushing, inversion, sauna, energy balancing, and Quantum Touch) is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the technique, pressure and/or strokes may be adjusted to my level of comfort.</i></p> <p><i>I understand that bodywork is not 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 that I am aware of. I understand that massage/energy therapists are not doctors, chiropractors, or psychiatrists and that therapists are not qualified to diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session 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></p> <p><i>I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be NO liability on the therapist's part should I forget to do so.</i></p> <p><i>I understand that illicit or sexually suggestive remarks or advances are undesired and will result in the immediate termination of the session. I understand that I will be liable for payment of the session and may be precluded from future massage services.</i></p> <p><i>I agree to pay for any appointment that I cancel without adequate advance notice (24-hour notice) or that I fail to keep unless it is due to an emergency situation. Additional fees may be applied and billed after the scheduled date of service.</i></p>			
<p>Client Name (printed) _____</p> <p>Client Signature _____ Date _____</p> <p>Therapist's Signature _____ Date _____</p>			