Naturalis Healing – Client Intake Form

All information is held in strictest confidence. At no given point is information disclosed or shared without client's written consent. You may choose to skip answering any question you feel impinges on personal information you do not wish to disclose.

- **Full Name ***
  First Name Middle Name Last
- **Address ***
  Street Address
  Street Address Line 2
  City Province
  Postal Code South Africa
- **Birth Date**
  Month Day Year
- **Phone Number ***
  This is my: Home No Cell No Work No
- **This is my: ***
  Home No Cell No Work No
- **E-mail ***
- **Emergency Contacts ***
  1) Next of kin Friend Other
  2) Next of kin Friend Other
  3) Next of kin Friend Other
  4) Next of kin Friend Other
- Occupation

- **Current Medications *** None ☐
  Description (state what you are taking medication for)
- **Allergies ***
  None ☐
  Description (state what you are taking medication for)
- **History of Pathology –**
- None ☐
- **1. List Areas of Discomfort or Pain**
- **2. Describe Onset of Discomfort or Pain**
- **3. Rate of Pain Today :**

  Mild ☐ Bearable ☐ Rate pain from 1-10 ☐
- **4. Frequency - please select the most accurate**
  ☐ Constant ☐ Off/On ☐ At Rest ☐ With Activity ☐
- **5. At what time of day is the pain at its worse?**
  ☐ Morning ☐ Afternoon ☐ Evening ☐ During Sleep ☐

- **6. Have you ever injured this area before?**

- **7. Have you ever been in an accident (automobile, work, falls, etc.) ?**

- **8. List all related treatments received for this injury.**

- **9. Have you ever received therapeutic massage for a specific problem or injury?**

- **Was the treatment used effective?**

  Yes ☐ No ☐ Somewhat ☐

- **10. Is there anything that you do that creates, increase or decreases pain?**

- **11. What are the physical duties required of your occupation?**

- **12. What activities/hobbies do you enjoy?**

- **13. Please list exercise and stress reduction activities (including frequency).**

- **14. In what position do you most often wake up in?**
  ☐ Back ☐ Side ☐ Stomach ☐

- **15. Are you currently seeing any other healthcare professional?**

Please check any symptoms that apply to you and indicate right or left when applicable:

- **Head**
  ☐ Temples ☐ Forehead ☐ Top of head ☐ In the eyes ☐ Entire head ☐ Base of skull ☐ Dizziness ☐ Fainting ☐ Light-headedness ☐ Pain in ears ☐ Ringing in ears ☐

- **Neck**
  ☐ Stiffness ☐ Pain at neck shoulder junction ☐ Pain when turning head ☐ Pain with side to side movements ☐ Neck feels out of place ☐ Muscle spasm in neck ☐ Gliding/Grating sound with neck movement ☐ Diagnosed bone spurs ☐ Diagnosed disc herniation ☐

- **Shoulders**
  ☐ Pain in shoulder ☐ Front ☐ Back ☐ Side ☐ Pain deep in shoulder joint ☐ Diagnosed bursitis ☐ Diagnosed Arthritis ☐ Can't raise arm above shoulder level ☐ Can't raise arm over head ☐

- **Arms & Hands**
  ☐ Pain in upper arm ☐ Pain in forearm ☐ Pain in wrist ☐ Pain in fingers ☐ Sensation of pins & needles in arm ☐ Sensation of pins & needles in fingers ☐ Fingers go to sleep ☐ Hands cold ☐ Swollen joints in fingers ☐ Sore joints in fingers ☐ Diagnosed arthritis ☐ Loss of grip strength ☐

- **Mid-Back**

  ☐ Mid-back pain ☐ Pain between shoulder blades ☐ Pain up/down back ☐ Pain across mid back ☐ Pain with breathing ☐ _____

- **Lower Back**

  ☐ Low back pain ☐ Low back pain is worse when working ☐ Low back pain is worse when lifting ☐ Low back pain is worse when stooping ☐ Low back pain is worse when standing ☐ Low back pain is worse when sitting ☐ Low back pain is worse when bending ☐ Low back pain is worse when coughing ☐ Pinched nerve in low back ☐ Low back feels out of place ☐ Pain up/down low back ☐ Pain across low back ☐ Diagnosed disc herniation ☐ _____

- **Hip**

  ☐ Pain in buttocks ☐ Pain in buttocks when standing ☐ Pain buttocks in buttocks when sitting ☐ Pain on side of hip ☐ Pain deep in hip joint ☐ Pain on sit bone ☐ Diagnosed bursitis ☐ Diagnosed arthritis ☐ _____

- **Legs and Feet**

  ☐ Pain down RIGHT leg ☐ Pain down LEFT leg ☐ Pain down BOTH legs ☐ Leg cramps ☐ Pin & Needles in RIGHT leg ☐ Pin & Needles in LEFT leg ☐ Numbness in RIGHT leg ☐ Numbness in LEFT leg ☐ Numbness in RIGHT foot ☐ Numbness in LEFT foot ☐ Numbness in toes ☐ Feet feel cold ☐ Cramps in RIGHT foot ☐ Cramps in LEFT foot ☐ Swollen RIGHT ankle ☐ Swollen LEFT Ankle ☐ Swollen RIGHT foot ☐ Swollen LEFT foot ☐ Pain in RIGHT Foot ☐ Pain in LEFT Foot ☐ Pain in RIGHT knee ☐ Pain in LEFT knee ☐ Diagnosed Arthritis ☐ _____

  Other – specify:

- **Aromatherapy Policies:**

Client services and chart information are confidential. Written authorization is required from you to release any information.

• Please turn off your cell phone for optimal relaxation

• Your scheduled session is set aside for you. We do not double book appointments

• 24 hour cancellation notice is required to avoid being charged for your session

• You will have a consultation with your therapist to discuss your session

• I understand that my therapeutic massage therapist or I may end the session at any time for any reason

• Inappropriate behaviour will not be tolerated and may be prosecuted to the full extent of the law

Client Agreement:

I understand that therapeutic massage therapists do **NOT** diagnose illness, disease, any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform joint mobilization.

I acknowledge that massage therapy is **NOT** a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for that service.

It is **my choice** to receive therapeutic massage as a form of therapy.

I understand that at any time I feel pain or discomfort during the session, I will immediately inform my therapeutic massage therapist so they he/she can adjust.

I have stated my pertinent medical conditions, and will update the massage therapist of any changes in my health status.

I understand that my failure to do so may post a threat to my health and/physical well being and I hold harmless Natural Scent Paradise and my therapeutic massage therapist

Name of Therapist _____ from **any liability** whatsoever arising from failure on my part.

By my signature below, I agree to the massage policy and client agreement above.

-
- Signed on DAY MONTH YEAR

Signature *

Witness: Please state your relation to the Signatory:

Witness Signature *