



SAGE WELLNESS

NEW CLIENT INTAKE FORM

Name: _____

Address: _____

City/State/Zip: _____

Birthday: _____

Phone: _____

Email: _____

Preferred contact method: _____

Emergency Contact: _____ Relation: _____ Phone: _____

BODY WORK HISTORY

How did you learn about Sage Wellness? _____

Have you received massage before? What style and frequency? _____

What is your major reason for seeking massage therapy? _____

When did you first notice this condition? _____

What aggravates it and what relieves it? _____

Has there been a medical diagnosis? _____

Are you experiencing loss of range of motion in this area or any others? _____

If currently pregnant, what is your due date? _____

Please circle all areas of the body which you give permission to receive massage:

Back Legs Feet Buttocks Arms Hands Abdomen Upper Pectorals Neck Head Face

What areas do you want to focus on? _____

Are you comfortable laying on your back and your stomach for long periods? _____

PERSONAL HABITS

What is your occupation and what position are you most commonly in everyday? (ex. sitting at desk) _____

What do you do when you are stressed? _____

What do you do for exercise? _____

What position do you sleep in? _____

MEDICAL HISTORY

Primary Health Care Provider: _____ Phone: _____

Other Practitioners regularly visited: _____ Phone: _____

Permission to consult with these individuals? _____

Are you currently being treated by a medical professional or psychotherapist? If yes, please explain. _____

Please list all medications and reason for taking them: _____

Please list (date and description) of any accidents or operations: _____

Please check any conditions which apply to you:

Musculo-skeletal

- ☐ Bone or joint disease
- ☐ Tendonitis or bursitis
- ☐ Fractured/broken bones
- ☐ Sprains/strains
- ☐ Spasm/cramps
- ☐ Arthritis
- ☐ Headaches
- ☐ Scoliosis
- ☐ Inflammation
- ☐ Jaw pain
- ☐ Other

Circulatory/Respiratory

- ☐ High or low blood pressure
- ☐ Heart condition
- ☐ Varicose veins
- ☐ History of blood clots
- ☐ Dizziness/fainting
- ☐ Asthma
- ☐ Allergies
- ☐ Sinus problems
- ☐ Difficulty breathing
- ☐ Lymphedema
- ☐ Other

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Other

Nervous System

- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐ Areas of numbness/tingling
- ☐ Herpes/ shingles
- ☐ Parkinson's Disease
- ☐ Other

Digestive

- ☐ Irritable bowel syndrome
- ☐ Constipation or Diarrhea
- ☐ Diverticulitis
- ☐ Other

Other

- ☐ Any infectious disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Currently Pregnant
- ☐ Alcohol/Nicotine/ Drug Addiction

Please explain any of the conditions checked above: _____

It is my choice to receive massage therapy and I understand that it is given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, and increasing circulation and energy. I agree that I will communicate with my practitioner if I feel my well being is being compromised.

In the case of hot stone massage, I understand that basalt stones warmed to 120 degrees Fahrenheit will be in direct contact with my skin during this treatment. Therefore, to avoid potential burns, I will communicate with my practitioner throughout the massage about my temperature comfort level.

I understand that massage practitioners do not diagnose illness/disease or prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I understand they may use manual tools such as cups, trigger point tools and gua sha tools to aid in my massage therapy goals.

I understand that cancellations without 24 hour notice will be charged a 50% missed appointment fee for the session. I also understand that late arrivals will be charged for the full amount for the service booked and will receive as much of the service as time allows.

I have provided accurate information on this form and will update my practitioner of any changes.

SIGNATURE: _____ DATE: _____

SIGNATURE of Legal Guardian (if applicable) _____ DATE: _____



SAGE WELLNESS Therapeutic Bodywork

Our Practice Policies

© I understand that Sage Wellness requires 24 hours notice for cancellation of appointments, with the exception of emergencies and severe weather. Cancellations without 24 hours notice will be charged a 50% missed appointment fee for the session scheduled. In the case of habitual last-minute cancellations, my credit card will required to be kept on file with Sage Wellness for missed appointment fee processing. If I am using health insurance for my massage treatment, I understand that this fee is my responsibility since it cannot be billed to my insurance company.

© I understand that late arrivals will be charged for the full amount for the service booked and will receive as much of the service as time allows.

© I agree that Sage Wellness LLC may release the necessary medical and other information required for processing health insurance claims when applicable. I authorize direct payment of medical benefits to Sage Wellness LLC for services provided and acknowledge that I am responsible for paying the full balance of my account if my insurance does not pay my claims for any reason and reasonable attempts have been made to collect the balance.

© I have read and understand the Notice of Privacy Policies available on www.sagewellness.com or in the office.

© I will notify Sage Wellness in writing if I prefer my appointment dates/times are never discussed with my family members for scheduling purposes. Details of treatment will remain confidential.

SIGNATURE: _____ DATE: _____