

**Confidential Client Intake Form**

Name \_\_\_\_\_ Date of Initial Visit \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Marital status \_\_\_\_\_ Referred by \_\_\_\_\_

Have you had-massage/bodywork before? \_\_\_\_\_ What type? \_\_\_\_\_

**Reason For Visit**

What is your primary concern? \_\_\_\_\_

What are other areas of concern? \_\_\_\_\_

When did your first notice it? \_\_\_\_\_

Describe any stressors occurring at the time \_\_\_\_\_

What activities provide relief? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Is this condition getting worse? \_\_\_\_\_ Interferes with Work \_\_\_\_\_ Sleep \_\_\_\_\_ Recreation \_\_\_\_\_

Describe your exercise routine (type, frequency) \_\_\_\_\_

Fluid Intake \_\_\_\_\_ Stress Level \_\_\_\_\_ Energy Level \_\_\_\_\_

**Medical History**

Are you currently under the care of another health care provider(s)? \_\_\_\_\_ Reason(s) \_\_\_\_\_

Name(s) of Practitioner \_\_\_\_\_ Address \_\_\_\_\_

Current Medications/Supplements/Remedies \_\_\_\_\_

Allergies (specify allergen and reaction) \_\_\_\_\_

Surgical History (year and type) \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Accidents or Traumas \_\_\_\_\_

**Please circle any of the following you have now or underline any that you have had in the past**

**Nervous System**

Shingles  
Numbness / Tingling  
Trigeminal Neuralgia  
Bell's palsy  
Sciatica  
Pinched Nerve  
Other \_\_\_\_\_

**Musculoskeletal**

Bone or Joint Disease  
Tendonitis / Bursitis  
Arthritis / Gout  
Sprains / Strains  
Spasms / Cramps Jaw Pain / TMJ  
Lupus  
Osteoporosis  
Muscular Tightness (location) \_\_\_\_\_  
Other \_\_\_\_\_

**Skin**

Allergies  
Rashes  
Athletes Foot  
Herpes / Cold Sores  
Fungus  
Other \_\_\_\_\_

**Circulatory**

Heart Condition  
Phlebitis / Varicose Veins  
Blood Clots  
High / Low Blood Pressure  
Lymph edema  
Thrombosis / Embolism  
Other \_\_\_\_\_

**Respiratory**

Asthma  
Emphysema  
Allergies  
Sinus Ailment  
Other \_\_\_\_\_

**Other**

Cancer / Tumors  
Kidney / Bladder Ailment  
Diabetes  
Drug / Alcohol / Caffeine / Tobacco  
Chronic Fatigue  
Chronic Pain  
Sleep Disorders  
Herniated or Bulging Disc (location) \_\_\_\_\_  
History of disordered eating

**Other**

Migraines / Headaches  
Inflammation / Swelling  
Infection  
Depression/ Anxiety  
Cold hands or feet  
Fever  
Communicable Diseases \_\_\_\_\_  
Contact Lenses – Hard or Soft  
Other \_\_\_\_\_

Is there anything else you would like me to know about your health? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Disclosure Statement and Consent Form

I understand that Sarah Lawrence, LMP (Ruby Moon Wellness) is not a doctor and that this work is not represented as a substitute for medical care. I have listed all my known medical conditions and will inform Sarah of any change in my health between massage sessions. I am also responsible for consulting a qualified primary care provider for any physical ailment(s) that I may have. I further understand that a massage practitioner neither diagnoses nor prescribes for illness, disease, or other medical, physical, or emotional disorders, nor performs any thrusting joint/spinal manipulations nor engages in any sexual activity during or under the pretense of a massage session.

I, the undersigned hereby authorize Sarah Lawrence, LMP (Ruby Moon Wellness) who is currently licensed in the State of Washington (Lic # MA00021717) to perform the following treatment procedures:

- **Acupressure:** Acupressure uses the fingers to skillfully press key points on the body. When these trigger points are pressed they release muscular tension, promote blood circulation, and assist the body's energy.
- **Aromatherapy:** The use of aromatic plants for medicinal and healing purposes. Essential Oils (volatile oils) are applied to the skin directly or mixed with carrier oil and then applied to the skin. Possible side effects of essential oils are headache or allergic reaction.
- **Dietary Advice:** Food and supplement advice based on nutritional and western medical herbal studies.
- **Herbal Remedies:** Medicinal plants that are used to help alleviate ailments of the body. As is the case with any medicine, not all remedies work for each person and some people may experience mild to severe side effects, which may include death, however this is very rare. It is also important to note that no herbs have been approved, by the FDA, as "medicine" in clinical trials and that herbal remedies are only approved under dietary supplements.
- **Massage:** Therapeutic massage addresses tension and holding patterns in muscles and connective tissue thereby helping to relieve pain, stress, tightness and restricted mobility of joints.
- **Pelvic Floor Release:** Massage, trigger point, and release work for the muscles that make up the pelvic bowl. This work is not internal pelvic floor work.
- **Arvigo Techniques of Maya Abdominal Therapy (Including Castor oil packs, uterine steams, and Rainforest Remedies herbal medicine):** Specific massage therapy and adjunct techniques for the abdomen, pelvis, sacrum, low back and hips that work to bring about correct positioning of organs that have shifted and now restrict the flow of blood, lymph, nerve & chi energy.
- **Prenatal Massage:** Therapeutic massage during pregnancy to address the specific changes and concerns of the pregnant body. Please notify the therapist if the pregnancy is considered high risk.

I recognize the potential risks and benefits of the procedures described above, including a potential for the aggravation of symptoms existing prior to treatment. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Sarah Lawrence, LMP (Ruby Moon Wellness) regarding the cure or improvement of my conditions. I understand and agree that I am receiving massage therapy entirely at my own risk. I hereby release Sarah Lawrence, LMP (Ruby Moon Wellness) from any and all liability which may occur in connection with the above-mentioned procedures. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

I understand that if I cancel with less than 24 hours notice or do not show up for an appointment I will be billed 80% of the service(s) reserved.

I understand that under HIPPA law health care providers are required to protect the privacy of your PHI: "Protected Health Information" which includes your name, contact information, notation of each visit and health information. Knowing this, I authorize Sarah Lawrence, LMP to take notes about my health during sessions. A full document on HIPPA law will be available to you if you would like further information.

**I have read and understood the above statements.**

\_\_\_\_\_  
Client Signature (or Parent/Guardian)

\_\_\_\_\_  
Date