MaryLou Nicholas
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Center for Integrated Health
140 Clemens Rd, Suite 104
Harleysville, PA 19438

Client Intake Form

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____Date of Birth: _____

Email: _____

Contact In Case of Emergency: _____ Phone _____

Name of Physician: _____ Phone: _____

>How did you hear about me? _____

Referral Name _____

>Have you ever had any of the following holistic therapies? (Please Circle)

Reiki Y or N, **Reflexology** Y or N, **Massage** Y or N,

Acupressure Y or N, **Aromatherapy/Raindrop Therapy** Y or N

If Yes, What kind of experiences/results did you have? _____

_____

>What would you like to focus on today? Physical Issues? Pain? Emotions? etc.

_____

_____

Do you exercise regularly? Y or N If so what type? _____

Do you follow a special diet? Y or N

If yes, Please describe your diet: _____

Do you drink at least 8 glasses of water a day? Y or N

How many caffeinated products do you drink in a day? _____

Do you have trouble sleeping? Y or N

How long have you had this issue? _____

Do you have a spiritual practice? Meditation? Prayers? Etc// Please describe:

_____

_____

_____

Health History

Please Circle any condition listed below that applies to you:

AIDS Allergies Anxiety Asthma/Breathing issues

Arthritis: Rheumatoid/ Osteo Artificial joints _____

Back Injury Back Pain: Low/ Middle /High

Blood Clotting issues Blood Pressure: Low /High

Blood Sugar issues: hypoglycemia Diabetes

_____

Bruise easily

Cardiac (Heart) Condition: Heart Attack Heart Disease Other (Please Describe)

_____

Cancer - If yes, What type? _____When were you diagnosed? _____ Are you still being treated? _____

Have you ever had radiation or chemotherapy? Y or N

Carpal Tunnel Syndrome Circulation disorder Cold symptoms

Contact Lenses Contagious Disease

Dentures Depression Epilepsy/seizure disorder Exhaustion/Fatigue

Fever Fibromyalgia Flu like symptoms Fractures

Headaches Hepatitis Hernia Herniated Disc Infection

Infertility Issues Joint Swelling Kidney Issues Lymphatic Disorders

Menstrual issues cramps/ PMS Menopause

Mood Swings Neck Injury Neck Pain Nerve disorder

Neuropathy Open Wounds

Pain, if yes please explain: _____

Pregnancy: Y or N If yes, what Trimester? _____

Recent Accident or Injury – If Yes, Please describe_____

Scars Scoliosis Shingles sinus problems skin conditions

Sprains /Strains Stress Stroke- If Yes, When? _____

Surgery - If yes, please list type and date: _____

Tendonitis TMJ problems Torn ligaments or tendons

Varicose veins

Other issues? _____

Please list any medications that you take:

_____

_____

_____

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Consent Form

I understand that Reiki, Reflexology, Massage and Energy work given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow.

If I experience any pain or discomfort during the session, I will immediately inform the therapist.

I understand the licensed massage therapist offering holistic services such as: Reiki, Reflexology, Massage and Energy work does not diagnose illness, disease or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal or skeletal adjustments/manipulations.

It has been made very clear to me that these holistic therapies are not substitutes for a medical examination and/or diagnosis or treatment, and that it is recommended that I see a physician for any physical ailment that I might have.

Because a licensed massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the therapist updated as to any changes in my medical profile.

I understand that there shall be no liability on the therapists part should I fail to do so.

I understand that all information will be kept strictly confidential.

Client Signature_____

Date _____