Holistic RI, LLC Health Intake Form: Manual Therapies

Date: / /

Name	Pronoun:
Phone	DOB: Sex:
Email	
Allergies	
	May the therapist use Aromatherapy? Y / N
Current Health	
Medications/vitamins herbal supplements *& reason for taking*	**Are you taking ANY blood thinning medication?**
Received this therapy (ie. reiki) before?	When / Where?
History	Smoking_____ Heart attack (MI)_____ Stroke (CVA)_____ Major illnesses_____ Surgeries _____ broken bones_____ Other_____
Current Experiencing any of the following?	Autoimmune _____ Reflux _____ Recent Surgery or injury _____ High Blood Pressure_____ Heart Problems_____ Poor Circulation_____ Headaches_____ Dizziness_____ Blood Clots_____ Diabetes_____ Neuropathy_____ Corns_____ Bunions_____ Plantar Warts_____ Warts_____ Digestive_____

Women

*****IT IS VERY IMPORTANT TO TELL YOUR THERAPIST IF YOU MAY BE PREGNANT*****

Are you currently pregnant or trying to become pregnant?_____

Have you gone through menopause? _____

➡
TURN OVER PLEASE

Please note - feet with current athletes foot cannot be worked on

Cancellation Policy

Cancellations made with less than 24 hours notice will be charged a fee.

Heat

We occasionally use heated stones and heated towels.
Please let us know immediately if anything is uncomfortable. Contraindications including the following must be disclosed; pregnancy, inflammatory skin conditions, high or low blood pressure, open wounds, varicose veins, and potentially heat sensitivity. Please ask your PCP if you have any contraindications to heat therapy prior to your session.

☐ I agree

Medically Cleared

I am medically cleared to receive this therapy. I do not have any blood clots, or athlete's foot. I will notify my therapist of any changes. I will alert my practitioner of any allergies, recent surgeries, limitations, or medical conditions. I will alert my practitioner of any medication that I am taking including blood thinners. (This is so that we can adjust our therapies to best suit your needs)

☐ I agree

Informed Consent

Holistic, complimentary therapies should not replace or interfere with the care of a physician. I understand that it is my responsibility to consult my physician prior to a wellness session. The holistic practitioner will not diagnose conditions or prescribe medications. By signing this form I give my consent to a holistic wellness session. I understand what it entails, as well as the cost of each session.

☐ I agree

Holistic RI Practitioner Permission

I give permission for Holistic RI practitioners to review this intake and share clinical findings. Only practitioners providing direct therapies or consulting will access this information. We take your privacy very seriously.

☐ I agree

Printed Name: _____

Signed:_____Date:_____