JustBreathe Wellness Center

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[**www.justbreathe-wellnesscenter.com**](http://www.justbreathe-wellnesscenter.com)

**Client Intake Form**

**Personal Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Massage Information**

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a professional massage before?

YES  NO If YES, how often\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sensitive to fragrance, perfumes or essential oils?  YES  NO

Do you have sensitive skin?  YES  NO

Do you exercise regularly?  YES  NO

If so, what type(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

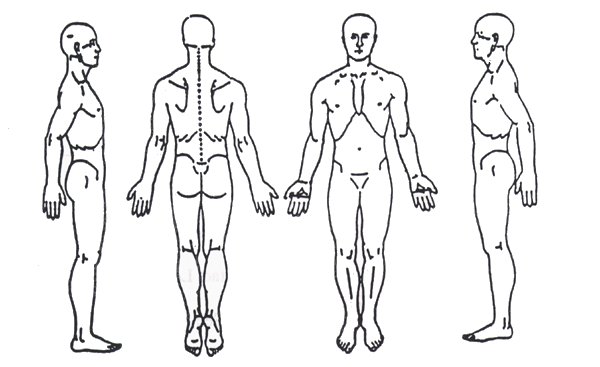
**What type of massage are you seeking today?**

Relaxation

Pregnancy

Therapeutic

**What are your common areas of pain or tension?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Circle any specific areas you would like the massage therapist to concentrate on during the session. LET YOUR THERAPIST KNOW IF YOU WANT ANY ADD ONs PRIOR TO YOUR SESSION TO SEE IF SCHEDULE ALLOWS.**

**Medical History**

Do you suffer from chronic or persistent pain/discomfort? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If so, for how long? \_\_\_\_\_\_\_

Do you know what cause it or when the symptom(s) seem to get worse or better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you current taking any prescription medication? If so, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under medical care?  YES  NO

**Please indicate any conditions that you have had or currently have:**

Abnormal Skin Conditions  Joint Replacement / Surgery

Allergies / Sensitivity  Major Accident (MVA/Slip &Fall)

Arthritis / Tendonitis  Neck / Back Injuries

Blood Clots  Numbness / Tingling / Weakness

Cancer / Tumor  Paralysis

Diabetes  Pregnancy

Fever  Recent Injuries

Fibromyalgia  Seizures / Epilepsy

Headaches / Migraines  Strain / Sprain

Heart / Circulation Problems  Sleep Pattern Disturbance

High / Low Blood Pressure  Lack of or Reduced Feeling / Sensation

Lyme Disease  Varicose Veins

**Informed Consent**

I understand that the massage/bodywork I receive is for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated here. I understand that the massage therapist does not diagnose any physical or mental illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. Nothing said in the course of the sessions(s) given should be construed as such. I understand that massage therapy is not a cure or substitute for any medical treatment and that it is recommended I work with my primary caregiver for any condition(s) I may have.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known physical conditions and medications and answered all questions honestly. I agree that failure to disclose this information shall not result in liability on the part of the practitioner. I will keep the massage therapist updated on any changes in my medical profile.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Consent to Treatment of Minor:**  By my signature below, I hereby authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  to administer massage / bodywork techniques to my child or dependent as deemed necessary.  Signature of Parent or Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Practitioner Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**COVID-19 Health Information & Informed Consent**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

**COVID-19 Information Please answer these COVID-19 health questions below:**

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐

2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes ☐ No ☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

4. Have you traveled anywhere outside of the state in the last two weeks? Yes ☐ No ☐

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Have you had a new loss of sense of taste or smell? Yes ☐ No ☐

**The following questions are specific to a new aspect of COVID-19 involving blood coagulation.**

6. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐

7. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes ☐ No ☐

8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes ☐ No ☐

JustBreathe Wellness Center Informed Consent for Treatment to proceed with receiving care, I confirm and understand the following **(Initial in all places provided)**

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. \_\_\_\_\_\_\_\_\_\_\_\_

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as “informed consent” and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. \_\_\_\_\_\_\_\_\_\_\_\_

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. \_\_\_\_\_\_\_\_\_\_\_\_

I have been offered a copy of this consent form. \_\_\_\_\_\_\_\_\_\_\_\_\_

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature (in case of a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_