# The Roots of Health

**CranioSacral Therapy, Therapeutic Massage, Reiki**
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## Client Intake Form

### Client Information

Name: ______________________________ Today's Date: ______________________

Street: ______________________________ Home Phone: ______________________

City: ______________ State: ____ Zip: ________ Cell Phone: ______________________

Occupation: ______________________________ Date of Birth: ______________ Current Age: _____

Referred By: ______________________________ Email: ______________________

Primary Physician Name and Phone: ______________________ (_____) ______________

Emergency Contact Name and Phone: ______________________ (_____) ______________

Unless specifically noted otherwise, provision of contact information assumes permission for The Roots of Health to contact you with questions or information related to your therapy, general information, or promotional offers.

### General Information

Have you ever had any of the following therapy services?

| Therapy | Yes / No | Date of Last Session | Anything you would like to share |
|---|---|---|---|
| Massage Therapy | | | |
| CranioSacral Therapy | | | |
| Reiki | | | |

List any exercise (including occupational activity like heavy lifting). Include frequency. ______________________

________________________________________________________________

Other recreational activities: ______________________________

On a scale of 1 to 10 (1 being the least), what is the amount of stress/tension in your life? ______________

Areas of tension in your body: ______________________________

Why are you here today? ______________________________

Anything else that would be helpful for you to share? ______________________________

### Medical Information

Currently under care of health practitioner for a specific condition/illness? ___ Practitioner's name: ______________

Condition/Illness: ______________________________

List current medications and purposes: ______________________________

________________________________________________________________

List injuries/accidents/illness. Please circle any still affecting you: ______________________

________________________________________________________________

Surgeries: ______________________________

________________________________________________________________

Mental Health/Psychological Conditions______________________________

## Medical Information Continued

Do you drink alcohol? _____ Yes _____No Frequency: ___________________________________

Do you smoke? _____Yes _____No Frequency: _____________________________________

How were you born (circle one)? Natural vaginal birth / forceps / suction / cesarean section

Please list any known birth traumas: ____________________________________________________________________________

Head Trauma. Please list any blows or injury to the head, and the location and manner of impact: ________________________

____________________________________________________________________________________________________________

Spine Trauma. Please list any blows or injury to the spine, and the location and manner of impact: _______________________

____________________________________________________________________________________________________________

Nerve problems. Please list any known nerve problems and their effects: ____________________________________________

____________________________________________________________________________________________________________

**Please CHECK all your current conditions. Put a STAR on the box if you had this in the past but do not any longer.**

Respiratory
□ Breathing difficulty / Asthma
□ Emphysema
□ Allergies specify:_______________________
□ Sinus Problems
□ Other:________________________________

Skin
□ Allergies specify:_______________________
□ Rashes
□ Athletes Foot
□ Plantar Warts
□ Herpes / Cold Sores
□ Edema
□ Other:________________________________

Digestive
□ Irritable Bowel Syndrome
□ Crohns Disease
□ Ulcers
□ Food Allergies specify:__________________
□ Other:________________________________

Musculoskeletal
□ Arthritis
□ Bone or Joint Disease
□ Degenerative Disease of the Spine
□ Scoliosis
□ Jaw Pain (TMJ)
□ Carpal Tunnel Syndrome
□ Other:__________________________________

Chronic or Acute Conditions
□ Diabetes
□ Cancer
□ Chronic Pain
□ Chronic Fatigue
□ Migraines
□ Fibromyalgia
□ Other:_______________________________

Nervous System
□ Sciatica
□ Shingles
□ Numbness / Tingling
□ Pinched Nerve
□ Stroke
□ Brain Injury
□ Other:_________________________________

Reproductive
□ Infertility
□ Pregnant: Stage _________________________
□ Ovarian/ Menstrual Problems
□ Breast Cancer/Surgery
□ Prostate
□ Other:_________________________________

Circulatory
□ Heart Condition specify:__________________
□ Phlebitis / Varicose Veins
□ Blood Clots
□ High / Low Blood Pressure (circle one)
□ Lymphedema
□ Thrombosis / Embolism
□ Thrombocytopenia
□ Other:_________________________________

Spectrum Disorders
□ Autism
□ Attention Deficit Hyperactive Disorder
□ Sensory Processing Disorder
□ Developmental Pervasive Disorder
□ Other:__________________________________

Mental
□ Stress □ Anxiety □ Depression
□ Bipolar
□ Schizophrenia
□ Post Traumatic Stress Disorder
□ Sleep Disorders
□ Other:______________________________

Because both Rachel Benbow and Ian Thomas, both here after referred to as the “therapist,” must be aware of existing medical conditions, I have stated all my known medical conditions and medications, and take it upon myself to keep the therapist informed about my updated physical health.

– I understand that the therapist cannot diagnose illness, disease, or any other medical, physical, psychological, or emotional disorder. I am responsible for consulting a qualified physician or medical practitioner for any physical/psychological ailments that I have.

– I understand that services offered by the therapist are not a substitute for medical care, and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature.

– I understand that Massage Therapy, CranioSacral Therapy and Reiki are therapeutic health aids.

– I understand that massage/bodywork is not appropriate care for infections or contagious illnesses or conditions. I will cancel my appointment as soon as I am aware of an infections or contagious illness or condition.

– I understand that the consumption of alcohol, recreational drugs, and pain killer pharmaceuticals can dangerously alter my body’s ability to register and give feedback about pain or other vital sensations. Consumption of these items can also create detrimental and potentially deadly reactions when combined with massage/bodywork. I agree to NOT consume alcohol, recreational drugs or pain killer pharmaceuticals prior to any treatment sessions.

– I understand that post treatment soreness can occur by the evening following a treatment session, and may last into the next day. In a small percentage of cases, soreness can last up to three days. Discomfort following treatment may be in an area that was treated, or in another area that is connected through a fascial restriction. The body’s tissues can experience discomfort during the post-treatment period due to release of restrictions and reorganization of the tissue. Drinking plenty of water and getting rest may help to minimize the temporary discomfort experienced following a treatment session.

– I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized, and I will pay for the fully scheduled session.

– I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

– I understand that the therapist is a volunteer responder for the CSMT Emergency Response Division, and that there may be rare occasions when the therapist may have to cancel and reschedule my session at short notice in order to assist at state or national emergencies/disasters.

– I understand that I will be charged, and agree to pay, a $2.75 processing fee when using a credit or debit card to pay for services or products. There are no additional fees for paying with cash or check.

– I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment.

– I understand that I will not hold this establishment or therapist liable for anything related to this treatment.

– I agree to actively participate as much as possible in my own healing.

________________________________________ ____________________

Client or Parent/Guardian Signature Date