Root Therapy Client Intake Form

Personal Information:

Name ___________________________ Phone (Day)________________ Phone (Eve) _________________

Address ____

City/State/Zip ____

email ___________________________ Date of Birth ______________Occupation __________________

Emergency Contact_________________________________ Phone ______________________________

Brief health history

1. Have you received complementary/alternative therapies in the past? Yes No
   If yes, what types of therapies have you received? ___________________________________

2. What brings you to the session today? Do you have specific goals or intentions in mind?

____

____

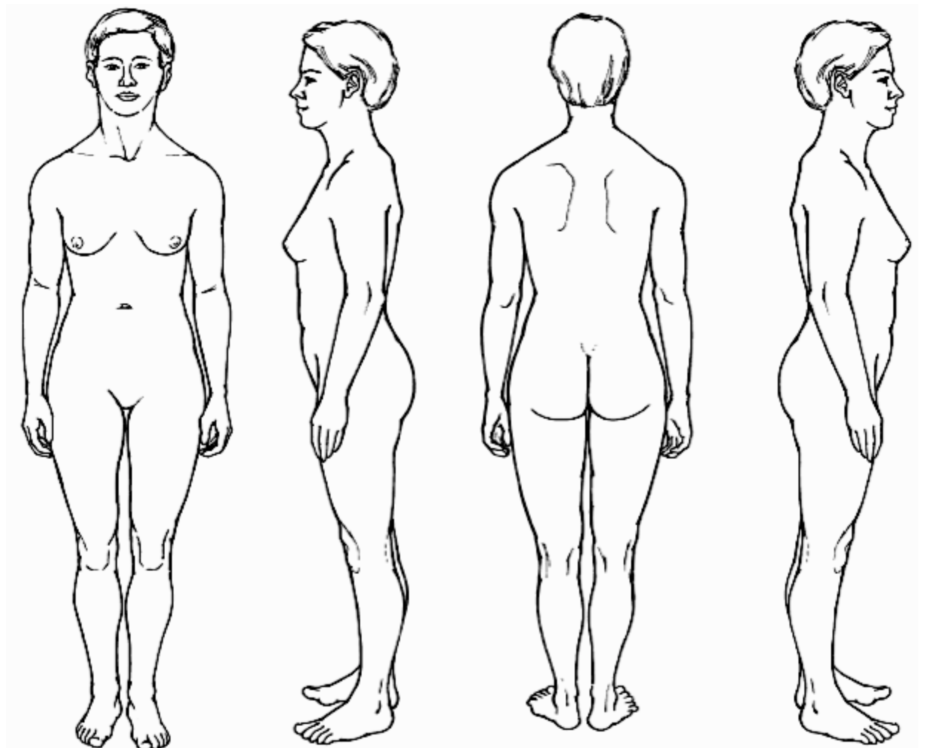
3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain ____

4. Do you perform any repetitive movement in your work (including sitting)? Yes No

   If yes, please describe ____

5. Circle any specific areas where you are experiencing tension, stiffness, pain or other discomfort.



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Medical History

6. Are you currently seeing a medical practitioner? Yes No

If yes, please explain____

7. Please list current medications (including aspirin, ibuprofen), supplements and herbs and reasons for taking these ____

____

8. Please list any surgeries, accidents or major illnesses, including dates & treatment received

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____

9. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent fracture
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/arthritis/ osteoarthritis/tendonitis
( ) HIV/AIDS
( ) fatigue
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) decreased sensation
( ) back/neck problems
( ) fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) digestive issues (IBS, crohns/colitis, constipation etc.)
( ) pregnancy. Stage? ______________
( ) diabetes
( ) eating disorders
( ) sleep disorders
( ) depression
( ) drug/alcohol addiction
( ) Other _________________________

10. Is there anything else about your health history that you think would be useful for me to know in order to plan a safe and effective session for you?

____

____

Consent for Care

I understand that it is my choice to receive body therapy. I acknowledge that body work is not a substitute for medical examination and diagnosis, and it is recommended that I maintain a relationship with my health care provider for that purpose. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health status. This treatment is being given for my well being. I agree to communicate with my practitioner any time I feel that my well being is compromised or my needs are not being addressed.

Signature______________________________ Date____________________

Root Therapy Practice Policies

Please review these policies and sign below. Thank you!

Cancellation
24 hour advance notice is required to cancel your appointment without charge. Please note that gift certificates cancelled within 24 hours of session will be voided.

No Shows
If you miss your appointment without notice, you will be charged for the appointment.

Forgiveness
Life happens! I do not charge the first time you either miss an appointment or cancel within 24 hours. For subsequent no-shows and cancellations, timely payment is required in full.

Late Arrivals
Sessions are scheduled for an allotted amount of time. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours.

Payment
Full payment is due at time of treatment.

Insurance
Although I do not bill insurance directly, I am happy to write you a receipt for the session, which you can submit to your insurance company for reimbursement.

Doctors notes
If you are under the care of a physician for a serious condition, a note from your doctor may be required before the session.

Exceptions & illnesses
I do understand that unanticipated events occasionally arise; in these cases exceptions may be considered on a case-by-case basis.

Yep, got it! I've read and agreed to these policies:

____

Name Date