



WELL INTO LIFE, LLC

a Collaborative Wellness Practice

Confidential Client Information

Name: _____ Date: _____

Address: _____ City / State/ Zip: _____

Phone: (cell) _____ (home) _____ (other) _____

Email: _____

Would you like to receive health and wellness tips?

Please check box to join our newsletter and/or receive special offers:

Occupation: _____ How did you hear about us? _____

Circle one: Groupon Google Yelp Bing Other: _____

Height: _____ Weight: _____ Date of Birth: _____

When was your last massage? _____

Primary Reason for Today's Visit: _____

Physician / Health Care professional: _____

What types of exercise do you engage in and how often? _____

Current Medications (include herbs, vitamins, etc.): _____

Allergies: *Please include any sensitivity to smells* _____

Please mark an "X" for all current conditions below. Please mark a "P" for all past conditions.

- | | | |
|--|--|--|
| <input type="checkbox"/> Acute/Chronic Pain | <input type="checkbox"/> Headache/Migraine | <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> Joint/Muscle Pain | <input type="checkbox"/> Neck/Spine Disorders | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> T.M.J. Syndrome | <input type="checkbox"/> Heart/Blood Conditions | <input type="checkbox"/> Skin Conditions/Athletes Foot |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Allergies | <input type="checkbox"/> Infectious Condition |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> P.M.S. Syndrome |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma/Lung Conditions | <input type="checkbox"/> Emotional Changes |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Flu/Cold/Infections | <input type="checkbox"/> Sleeplessness |
| <input type="checkbox"/> Pregnancy | | |
| <input type="checkbox"/> Other Medical Conditions not listed _____ | | |

Areas of limited movement: _____ Areas sensitive to pressure: _____

Please list any surgeries, accidents, or injuries & when: _____



WELL INTO LIFE, LLC

a Collaborative Wellness Practice

INFORMED CONSENT FORM

I understand if I experience any pain or discomfort during my session(s) I will immediately inform the therapist, so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork is not to be used as a substitute for medical examination, diagnosis, or treatment by a physician. I acknowledge that if I have any mental or physical condition I should see a qualified physician, chiropractor, or other professional health care specialist. Because massage should not be done under certain medical conditions, I affirm I have stated all my known medical conditions and answered all questions truthfully. I agree to keep the therapist updated as to changes in my medical conditions and understand that there shall be no liability on the part of Well Into Life, LLC or the therapist should I forget to do so.

Collaborative Wellness Practice - I understand that Well into Life, LLC, offers the services of a complement of skilled practitioners from various massage and bodywork modalities. ***I will inform my therapist if I do not wish to have my case discussed confidentially within the practice to provide me with suggestions or alternatives/options for my treatment.***

Acknowledgement and Consent to Receive Services - I understand the therapists at Well Into Life, LLC are not physicians and are not trained to diagnose illness, make recommendations involving pharmaceutical drugs or surgery, or handle medical emergencies. I have consented to use the services offered by Well Into Life, LLC, and agree to be personally responsible for the fees in connection with the services provided to me.

Cancellation Policy

We require at least 24 hours notification of cancellation. Otherwise, you may be billed a \$35 missed appointment fee.

Please indicate your acknowledgement and acceptance of these statements by signing below.

Signed: _____ Date: _____

Parent or Guardian of: _____

We offer a variety of modalities to serve your health and healing goals. Would you like to know more about our other services? (check all that apply):

- Massage Therapy
- Energy Medicine
- Structural Integration
- Biodynamic Craniosacral Therapy