WELL INTO LIFE, LLC

a Collaborative Wellness Practice

Confidential Client Information

Name: ____ Date: ____________________

Address: __________________________________ City / State/ Zip: ____________________

Phone: (home) ______________________(work)___________________ (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? __________________

Height: _______________ Weight: ____________ Date of Birth: ______________

Previous Experience with 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.): ____________________________________

____

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

____ Acute/Chronic Pain	____ Headache/Migraine	____ Diabetes/Hypoglycemia
____ Joint/Muscle Pain	____ Neck/Spine Disorders	____ Digestive Problems
____ T.M.J. Syndrome	____ Heart/Blood Conditions	____ Skin Conditions/Athletes Foot
____ Fibromyalgia	____ Allergies	____ Infectious Condition
____ Carpal Tunnel	____ High/Low Blood Pressure	____ Cancer/Tumors
____ Numbness/Tingling	____ Varicose Veins	____ P.M.S. Syndrome
____ Arthritis	____ Asthma/Lung Conditions	____ Emotional Changes
____ Osteoporosis	____ Flu/Cold/Infections	____ Sleeplessness
____ Pregnancy		

____ Other Medical Conditions not listed____

Areas of limited movement: ____________________ Areas sensitive to pressure: __________________

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

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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 in order 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, I 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