



# Sierra Nevada Holistic Services, LLC ("SNVHS")

407 W. Robinson St.  
Carson City, NV 89703  
775-720-2563

## Therapeutic & Medical Bodywork Intake Form

**PLEASE NOTE: THIS IS A 3-PAGE FORM**

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  Male  Female  Gender Neutral

Preferred Pronouns: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_, State \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer/School \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: ( ) \_\_\_\_ - \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed Domestic Partner

Whom may we thank for referring you to our office? \_\_\_\_\_

### **MEDICAL HISTORY AND MEDICAL INFORMATION**

Please take a moment to carefully read the following information and sign/initial where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to services being provided.

What are your goals of the session? \_\_\_\_\_

Last professional massage or bodywork session/treatment? \_\_\_\_\_

What type of pressure is preferred? Light Moderate Deep Mixed

Same pressure on whole body? YES NO

Any allergies to lotions, oils, or essences? YES NO What? \_\_\_\_\_

Any areas to avoid either for personal or medical reasons? \_\_\_\_\_

Are you able to lay face down without difficulties? YES NO \_\_\_\_\_

Are you currently under the care/supervision of a physician and/or alternative medicine provider (ex. Chiropractor, Oriental Medical Doctor, Medical specialist) for the reason you are here today?

YES NO

May we contact them to coordinate care, if necessary? YES NO

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please list any and all medications (prescribed OR over-the-counter), herbs, supplements, and vitamins that you are currently taking:

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*Please mark an (X) by all current conditions and (P) for all past conditions*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abdominal/digestive problems | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Pregnancy          |
| <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Drugs/Alcohol Use       | Weeks/Trimester: _____                      |
| <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Rash/fungus        |
| <input type="checkbox"/> Arthritis/tendonitis         | <input type="checkbox"/> Headaches, migraine     | <input type="checkbox"/> Sexual issues      |
| <input type="checkbox"/> Asthma or lung cond.         | <input type="checkbox"/> Hearing problems        | <input type="checkbox"/> Sinus problems     |
| <input type="checkbox"/> Athlete's foot               | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Blood clots                  | <input type="checkbox"/> Blood pressure          | <input type="checkbox"/> Spinal disorders   |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Jaw pain/TMJ pain       | <input type="checkbox"/> Sprain/strain      |
| <input type="checkbox"/> Circulatory/heart Problems   | <input type="checkbox"/> Muscle/bone injuries    | <input type="checkbox"/> Tension/stress     |
| <input type="checkbox"/> Cholesterol issues           | <input type="checkbox"/> Muscle/joint pain       | <input type="checkbox"/> Thyroid (High/Low) |
| <input type="checkbox"/> Constipation/diarrhea        | <input type="checkbox"/> Numbness/tingling       | <input type="checkbox"/> Vision problems    |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Pain (Chronic or Acute) | <input type="checkbox"/> Varicose veins     |
|   |  | <input type="checkbox"/> Other _____        |

Please list any recent injuries or surgeries within the past 5 years:

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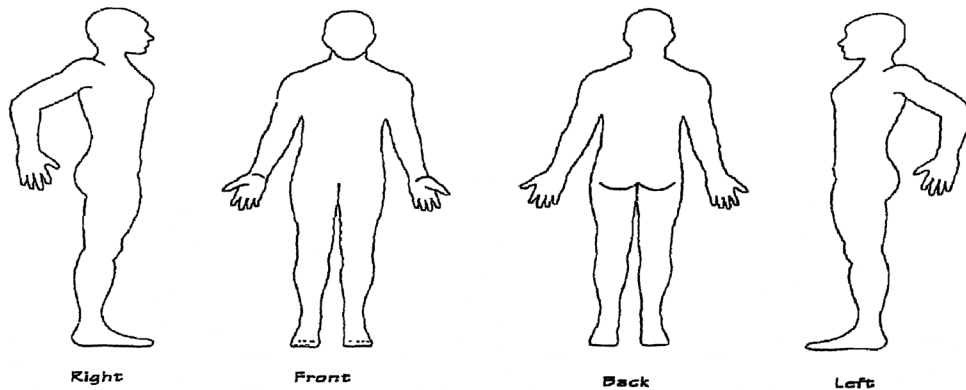
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Please list your stress-reduction activities, hobbies, exercise and/or sport participation:

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**Please indicate areas you experience pain/discomfort:**



**SNVHS Massage/Bodywork Consent & Release of Liability Form**

I understand the massage/bodywork I receive is for the purposes of stress reduction, relief from muscular tension/spasm(s)/pain, and to increase circulation and mobility/function. If I experience any pain, discomfort or become uncomfortable with the treatment being provided, I will immediately inform my therapist to adjust the pressure and/or change of methods to adjust to my comfort level. I also understand my massage/bodywork therapist does not perform any spinal manipulations. I acknowledge my therapist/bodyworker is not a replacement for medical examination, diagnosis or treatment. However, I understand my therapist (if a mid-level provider) does have the ability to diagnose illness/disease and prescribe medications/treatments. I understand I have the option to see my medical provider for these services. Treatment planning and advanced treatments (i.e., injections) shall be discussed and informed consent obtained prior to treatment.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep the massage/bodywork therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand the treatment of massage/bodywork may result in illness, personal injury, and even death. I KNOWINGLY AND VOLUNTARILY ASSUME ALL SUCH RISKS, BOTH KNOWN AND UNKNOWN. In the event of injury, illness, disablement or death either directly or indirectly as a result, in whole or in part, of the aforesaid therapy, I agree on behalf of myself, my heirs, executors, administrators and assigns to forever waive, indemnify and hold harmless, release and discharge SNVHS, the massage/bodywork therapist, their principals and agents from any and all claims, damages, demands, right of action or causes of action, either present or future, known or unknown, anticipated or unanticipated, resulting from or arising out of any relationship, interaction or transaction in any way connected with the massage/bodywork therapy.

Body parts that may be massaged included the face, neck, shoulders, back, arms/hands, buttocks, hip flexors, legs (front and back), pectorals, abdominals, ribs and feet. The massage/bodywork therapist will not engage in breast massage unless requested by the client and a signed consent is in place. Genital massage is illegal in this establishment. Standard draping will be used, unless otherwise agreed upon by the therapist and the client. Sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. The session will be terminated immediately, and the client will be responsible for the cost of the session in full. Client will be dismissed from SNVHS.

**Initials:** \_\_\_\_\_

**Cancellation and Late Fee Policy**

We make a commitment to you to guarantee your appointment time and refuse all other's requests once you have made the appointment. A 24-hour cancellation notice is required for any scheduled appointments. Missed or no-call/no-show appointments will result in you being charged the full amount of the session booked. We will still provide you services, but at a pro-rated time frame for the remaining scheduled appointment time. You will still be charged the full amount of the session originally booked. Emergency cancellations are determined the therapist's discretion. If no-shows or late cancellations happen more than twice, you may be asked to pay for your session in advance.

**Initials:** \_\_\_\_\_

**Consent to Treat a Minor/Dependent**

By my signature below, I hereby authorize a NV State Licensed Massage Therapist at SNVHS to administer bodywork to my child/dependent, as they deem necessary.

**Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Your signature and initials indicate you have read and agree to the terms listed herein.**

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

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_