

# Healing Light

## Health History Intake Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Primary Care Giver: \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_

Have you had professional bodywork before? \_\_Y \_\_N

What kind of bodywork? \_\_\_\_\_

What kind of pressure do you prefer? \_\_\_ Light \_\_\_ Medium \_\_\_ Firm \_\_\_ Not Sure

What are your massage and bodywork goals? \_\_\_\_\_

What is your general health? \_\_\_\_\_

I have had or currently experiencing: Please check all that apply. Thank you.

Please use the space below to describe details of items checked:

Fever	Stress	High Blood Pressure
Low Blood Pressure	Sprains	Strain
Headaches	Heart Trouble	Back Pain
Neck Pain	Diabetes	Varicose Veins
Joint Problems / Arthritis	Muscle Tension	Muscle Spasms
Skin Problems	Cancer	Seizures
Herpes	Any Contagious Disease	Allergies/Sensitivity
Inflammation	Pregnancy	Other

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Please list any recent surgeries and past or current injuries, including the date and nature of the surgery/injury:

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Please list any medication ( prescription or over-the-counter) or supplement you are currently taking. Please include the name, dosage, and purpose of the medication:

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Is there any other information you think I should know about? Please explain:

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I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform you so that pressure of strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part if I should fail to do so. I also 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 payment of the scheduled appointment. I am aware of the 24 hour notice to cancel my appointment and If I do not do so I am aware that I might be billed for the appointment.

**Consent to Treatment:**

Client Signature: \_\_\_\_\_

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

Consent to treatment of Minor

By my signature below, I hereby authorize Healing Light (Gregory A. Phillips) to administer massage/bodywork techniques to my child or dependent as he or she deems necessary.

Parent or Guardian

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

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