Heavin's Touch

INTAKE FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : ____/____/____ **Gender** : ☐ Male ☐ Female

Address : ____

Phone Number : ____ **E-Mail** : ____

Status : ☐ Single ☐ Married ☐ Divorce ☐ Others

Occupation : ____ **Are You A Retiree ?** : ☐ Yes ☐ No

How Did You Hear About Us? : ☐ Google ☐ Social Media ☐ Referral ☐ Other

Referral Name : ____

EMERGENCY CONTACT DETAILS

Contact Name : ____ **Home Number** : ____

Relationship : ____ **Mobile Number** : ____

OFFICE USE ONLY

Date : ____ **Membership Type** : ____

Payment Type : ____

Staff Name : ____ **Staff Signature** : ____

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910.604.0257
heavinstouch2@gmail.com
WWW.HEAVINSTOUCH.COM

INTAKE FORM

GENERAL HEALTH INFORMATION

Have you had or experienced any of the following issues ? Please Circle Any That Apply:

Respiratory

Asthma
Chronic Cough
Shortness of Breath
Emphysema
Bronchitis

Skin

Bruise Easily
Melanoma
Skin Irritations
Skin Conditions
Hypersensitive Reaction

Cardiovascular

Blood Clots
Pacemaker
Congestive Heart Failure
Stroke
Cerebral - vascular accident
Myocardial Infarction
Cold Hands
Varicose Veins
Low Blood Pressure
Heart Attack
Cold Feet
Thrombosis/Embolism
High Blood Pressure
Cardiovascular Accident
Phlebitis
Lymphedema
Heart Disease

Head & Neck

Ear Issues
Sinus Issues
Jaw Pain (TMJD)
Migraines
Hearing Loss
Vision Problems
Headaches
Vision Loss

Infectious Conditions:

Athlete's Foot
Skin Conditions
Respiratory
Conditions
Herpes
Hepatitis
HIV

WHAT CAN WE DO FOR YOU TODAY?

Issue of cause or concern? : _____

How Long Since You First Noticed? : _____

Describe Your Treatment Goals : _____

_____

Past Treatments? : _____

_____

How Long Has It been since your last massage? : _____

INTAKE FORM

GENERAL HEALTH INFORMATION

Please list all current Medications you are taking (pharmaceutical, OTc, Herbs/Supplements * : _____

_____

_____

POLICIES/PROCEDURES/COVID-19 DISCLOSURE

Have You had any Covid-19 Symptoms including fever of 100 degrees or above in the past 24-hours? Do you now or have you recently had respiratory or flu symptoms, sore throat or shortness of breath? Have you been in contact with anyone Covid-19 Positive?

Circle One: YES. NO

Please take a moment to read the following information. Please sign and date to state that you have read and agree to all of the policies.

I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
I affirm that I have notified my therapist of all known medical conditions and injuries.
I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
I understand that massage is entirely therapeutic and non-sexual in nature.
By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

Signature : _____

Today's Date: : _____