Thorne Wellness

Megan Thorne

MM41670 MA89842

Client Intake

Client Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Address: _____ Phone: _____

Email: _____ Occupation: _____

Emergency contact: _____ Phone: _____

Physician/Health- care Provider name: _____

Phone: _____

How did you hear about Thorne Wellness? _____

Is this massage medically necessary (is it for a medical condition. injury. surgery) ? Yes [✔] No [✔]

Do you have a physician referral/prescription? Yes [✔] No [✔]

Are you currently pregnant? Yes [✔] No [✔]

Are you currently nursing? Yes [✔] No [✔]

Do you have any special accommodations that need to be prepared for?

Yes [✔] No [✔]

If yes. please explain.

Have you ever received a professional massage before?

Yes [✔] No [✔]

How recently?

What kind of pressure do you prefer? Light Medium Firm

What types of physical activities do you enjoy?

What brings you in today (Be specific) ?

Rate your current stress level on a scale of 1- 10. _____

Rate your current pain level on a scale of 1- 10. _____

What are your goals/expected outcomes for receiving massage (Be specific) ?

List and prioritize your current symptoms/issues (stress. pain. stiffness. numbness/tingling. swelling. etc.) :

Do these symptoms interfere with your activities of daily living (e.g.. sleep. exercise. work. childcare) ? Yes ☑ No ☑

Explain:

List the medications you currently take:

Do you have any allergies? If yes. what are they?

Health History

Have you had any injuries or surgeries in the past 12 months? Yes ☐ No ☐

If yes, explain:

Have you had any injuries or surgeries in the past that may influence today's treatment?

Circle any of the following health conditions that you currently have.

blood clots, infections, congestive heart failure, contagious diseases, pitted edema.

** Please answer honestly, as massage may not be indicated for the above conditions. **

Please indicate conditions that you have or have had in the past.

Muscle or joint pain ☐ Current ☐ Past

Muscle or joint stiffness ☐ Current ☐ Past

Numbness or tingling ☐ Current ☐ Past

Health History

Swelling ✔ Current ✔ Past

Bruise easily ✔ Current ✔ Past

Sensitive to touch/pressure ✔ Current ✔ Past

High/Low blood pressure ✔ Current ✔ Past

Stroke. heart attack ✔ Current ✔ Past

Varicose veins ✔ Current ✔ Past

Shortness of breath. asthma ✔ Current ✔ Past

Cancer ✔ Current ✔ Past

Neurological disorder ✔ Current ✔ Past

Epilepsy. seizures ✔ Current ✔ Past

Headaches. Migraines ✔ Current ✔ Past

Dizziness. ringing in the ears ✔ Current ✔ Past

Digestive conditions ✔ Current ☑ Past

Kidney disease. infection ☑ Current ✔ Past

Arthritis ✔ Current ✔ Past

Osteoporosis ✔ Current ✔ Past

Degenerative spine/disk ✔ Current ✔ Past

Scoliosis ✔ Current ✔ Past

Broken bones ✔ Current ✔ Past

Diabetes ✔ Current Past

Endocrine/thyroid conditions ✔ Current ✔ Past

Depression. anxiety ✔ Current ✔ Past

Memory Loss ✔ Current ✔ Past

*** I agree that all the information that I have provided is true and accurate as far as my knowledge. *** Yes [ ] No [ ]

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Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or another qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said during 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that either party may end the session at any time. 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. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor) : Date: _____

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Thorne Wellness Policies

Please initial each line. and sign at the bottom.

_____ Cancelation Policy

You may cancel your appointment up to 24 hours before the scheduled service time. Same- day cancelations WILL result in a $50 cancelation fee. (Exceptions may be made. but this is solely up to the discretion of the therapist.)

_____ Sexual Misconduct

There will be ZERO tolerance for all sexual misconduct. Violation WILL result in immediate dismissal. You will be charged for your appointment. You WILL be banned from returning. Legal action WILL be taken if deemed necessary.

_____ General Misconduct

There will be a ZERO tolerance policy for general misconduct. Violation WILL result in immediate dismissal. You will be charged for your appointment. You WILL be banned from returning. Legal action WILL be taken if deemed necessary.

_____ Stealing

There will be a ZERO tolerance policy for theft. Violators will be persecuted to the fullest extent of the law.

_____ Drugs and Alcohol Policy

DO NOT arrive for your appointment under the effects of illicit drugs or alcohol. Violation WILL result in immediate dismissal. You will be charged for your appointment. You WILL be banned from returning. Legal action WILL be taken if deemed necessary.

_____ Sick Policy

Do not come in for your appointment if you are sick. Not only will that potentially contaminate your therapist and other clients. but it is also a contraindication for massage and could make your condition worse.

Client Signature: _____ Date: _____