Soulful Waters Client Intake Form

Name ______________________________________ Mobile Phone (_____) ___________________ DOB _________________

Address ____ City ________________ State ________ Zip __________

Would you like to receive Email newsletters with promotions? ____ Yes ____ No

If yes for Email, Email Address ____

How did you hear about us? ____

Emergency Contact _________________________ Relationship _____________________ Phone (_____)_________________

Occupation _________________________

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

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes No Do you frequently suffer from stress?
Yes No Do you have diabetes?
Yes No Do you experience frequent headaches?
Yes No Are you pregnant? Due Date_____
Yes No Do you suffer from arthritis?
Yes No Are you wearing contact lenses or dentures?
Yes No Do you have cardiac or circulatory problems?
Yes No Do you have high blood pressure?
Yes No Are you taking high blood pressure medication?
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have varicose veins?
Yes No Do you have any contagious diseases?
Yes No Do you have osteoporosis?
Yes No Do you have any allergies or sensitivities?

Additional comments ___________________________
____

Yes No Do you bruise easily?
Yes No Any broken bones in the past two years?
Yes No Any injuries in the past two years?
Yes No Do you have tension or soreness in a specific area?
Please specify:

Yes No Do you suffer from back pain?
Yes No Do you have numbness or stabbing pains?
Yes No Are you sensitive to touch or pressure in any area?
Yes No Have you ever had surgery? Year(s):___________
Yes No Do you use any topical hormones?
Yes No Do you have disk herniation?
Yes No Other medical conditions or are you taking any medications I should know about
____
____

Have you ever experienced a professional massage or bodywork session? Yes No How recently? _______________

What is the primary problem that brings you in for Myofascial Release today? ____________________________________

Secondary problem? ____

When and how did your symptoms begin?____

If you are in pain, how would you rate your pain on a scale from 1 – 10 (10 is the worst)?

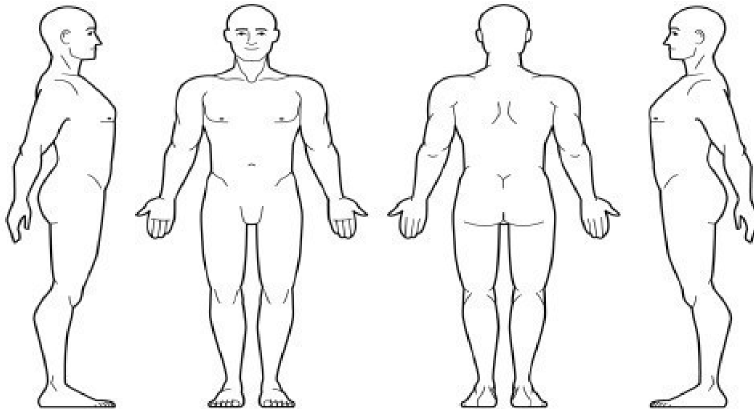
Please list any surgeries, accidents, or other conditions and the dates that you have had throughout your life.

What other types of therapies have you tried for this issue?____

Do you have a pacemaker, insulin pump, or any other implanted medical device?

Please list your therapeutic goals for this session.____

Please shade areas of pain in the diagram below:



Have you had a fever in the last 24 hours of 100° F or above? Yes No

Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes No

Do you now, or have you recently had any chills, muscle aches, new loss of taste or smell, or new rashes or lesions? Yes No

Have you been in in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes No

I give Smith Young permission to provide Myofascial Release therapy. If I experience any pain or discomfort during this session, I will immediately inform Smith Young so that the techniques may be adjusted to my level of comfort. I further understand that Myofascial Release should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that Smith Young is 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 Myofascial Release 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 Smith Young updated as to any changes in my medical profile and understand that there shall be no liability on Smith Young's part should I fail to do so.
I understand that, because Myofascial Release work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive Myofascial Release from Smith Young. 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.

Client Signature ____ Date _____________

Parent or Guardian Signature (If client under 18) ______________________________________ Date _____________

Soulful Waters Myofascial Release, LLC