Rhea Healing Essentials
121 N 85th St
Seattle, WA 98103

Confidential Client Health Intake Form

Name: _____ **Date**: _____

Address: _____ **City**: _____

State: _____ **Zip:** _____ **Date of Birth**: _____

Phone number: _____ **Email**: _____

Occupation/Employer: _____

Emergency Contact: _____ **Phone:**_____

How did you hear about Rhea? _____**Referred By**: _____

Would you like to be on our mailing list for special offers and newsletters? YES_____ NO_____

Have you ever had a professional massage or Reiki treatment before? _____

How frequent do you get treatments? _____

What do you hope to accomplish from today's massage/Reiki treatment? _____

Where are you feeling tension or pain in your body? _____

Please list any medications you are currently taking (including over the counter and herbal remedies):_____

_____

How often do you exercise? _____ **What do you do for exercise?** _____

_____

Are you currently receiving treatment from a medical practitioner, chiropractor, or physical therapist? _____

If yes, please explain: _____

Are you currently experiencing any of the following conditions?

___ Fever ___ Flu/Cold ___Infection ___Contagious diseases or skin disease

Please list any surgeries with approximate dates: _____

_____

Injuries or accidents that still affect you:_____

More on reverse side

Check ALL Current and Previous Conditions (Please explain)

GENERAL

Current	Past		Comments
____	____	Headache	_____
____	____	Pain	_____
____	____	Sleep disturbances	_____
____	____	Fatigue	_____
____	____	Sinus	_____
____	____	other	_____

SKIN CONDITIONS

Current	Past		
____	____	Rashes	_____
____	____	athlete's foot, warts	_____
____	____	other	_____

MUSCLE AND JOINT

Current	Past		
____	____	Rheumatoid arthritis	_____
____	____	Osteoarthritis	_____
____	____	Osteoporosis	_____
____	____	scoliosis	_____
____	____	broken bones	_____
____	____	spinal problems	_____
____	____	disk problems	_____
____	____	Lupus	_____
____	____	TMJ, Jaw pain	_____
____	____	spasms, cramps	_____
____	____	sprains, strains	_____
____	____	tendonitis, bursitis	_____
____	____	Stiff or painful joints	_____
____	____	weak or sore muscles	_____
____	____	Other	_____

NERVOUS SYSTEM

Current	Past		Comments
____	____	head injuries, concussions	_____
____	____	dizziness, ringing in ears	_____
____	____	memory loss, confusion	_____
____	____	numbness, tingling	_____
____	____	sciatica, shooting pain	_____
____	____	chronic pain	_____
____	____	depression	_____
____	____	other	_____

RESPIRATORY, CARDIOVASCULAR

Current	Past		Comments
____	____	Heart disease	_____
____	____	Blood clots	_____
____	____	Stroke	_____
____	____	Lymphedema	_____
____	____	high, low blood pressure	_____
____	____	irregular heart beat	_____
____	____	poor circulation	_____
____	____	swollen ankles	_____
____	____	Varicose veins	_____
____	____	chest pain	_____
____	____	Shortness of breath	_____
____	____	Asthma	_____

ALLERGIES

Current	Past		Comments
____	____	scents, oils, lotions	_____
____	____	detergents	_____
____	____	other	_____

DIGESTIVE/ELIMINATION DIET

Current	Past		Comments
____	____	Bowel problems	_____
____	____	gas, bloating	_____
____	____	bladder/kidney/prostate	_____
____	____	abdominal pain	_____
____	____	other	_____

ENDOCRINE SYSTEM

Current	Past		Comments
____	____	Thyroid	_____
____	____	Diabetes	_____

REPRODUCTIVE SYSTEM

Current	Past		Comments
____	____	Pregnancy	_____
____	____	painful, emotional menses	_____
____	____	fibrotic cysts	_____

CANCER/TUMORS

Current	Past		Comments
____	____	Benign	_____
____	____	Malignant	_____

HABITS

Current	Past		Comments
____	____	tobacco	_____
____	____	alcohol	_____
____	____	drugs	_____
____	____	coffee, soda	_____

Consent for Care

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health. I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physical for any physical ailments that I have.

I agree to give 24 hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hours notice to cancel or reschedule.

Signature_____ _____ **Date**_____