St. Johns Wellness Center, LLC

305 Kingsley Lake Dr., Suite 702
St. Augustine, FL 32092
MM 18687

CONFIDENTIAL CLIENT INTAKE / CONSENT FORM

Name_____**Date of Birth**_____

Address_____**City**_____**State**_____**Zip**_____

Home Phone_____**Cell Phone**_____

E-Mail (used for log in to website and updates from SJWC)_____

Occupation_____**How did you hear about us?** _____

Have you ever experienced a professional massage? _____ **How recently?** _____

Have you ever experienced a professional reflexology session? _____ **If yes, what was your experience?**

What are your goals for your massage and /or reflexology sessions?

Do you have tension or soreness in a specific area? _____ **Please Specify**

What makes it feel better?

What makes it feel worse?

Are you under a physicians care? _____ **If yes, what for?** _____

Any surgeries in the past 2 years? _____

Any accidents in the past 2 years? _____

Do you have any of the following conditions?

____ High blood pressure	____ Diabetes	____ Inflammation	____ Numbness
____ Heart Disease	____ Epilepsy	____ Head Aches	____ Skin Disorders
____ Cancer	____ Fibromyalgia	____ Insomnia	____ Infections
____ Circulatory disorder	____ Allergies	____ Arthritis	____ Digestive Problems
____ Contagious Disease	____ Low Back Pain	____ Neck / Shoulder Pain	

Anything else I should know about your feet, hands, or general health?

Please list any medications that you are taking:

Please turn over

Please take a moment to read the following, sign and date.

If you have a specific medical condition or symptoms (including infectious skin conditions), a referral from your primary care provider may be required prior to service being rendered.

~ I understand that the information I give on this form will be confidential, and will be used for no other purpose than treatment protocol and the therapistôs clinical studies.
~ I understand that the bodywork I receive is provided for the basic purpose of relaxation and relief of muscle tension. If I experience any pain or discomfort during my sessions, I agree to inform the therapist immediately so that pressure and /or technique may be adjusted to my level of comfort.
~ I understand that the therapistôs services are designed to support me and my health, and are not offered as a substitute for medical care. I understand that the information provided me is educational in intent, and not diagnostically prescriptive in nature.
~ Because bodywork is contraindicated under certain health conditions, I affirm that I have disclosed all known health conditions and answered all questions honestly. I agree to keep the therapist updated as to changes in my health and my use of pharmaceuticals, and agree that there shall be no liability on the therapistôs part should I not do so. I understand that it is the therapistôs legal responsibility to end, refuse or substitute service if, based on her knowledge, the requested service has the potential to do harm.
~ Since there are considerations for receiving bodywork during the first trimester of a pregnancy, I affirm that I have disclosed if I am pregnant at time of my services.
~ Because receiving bodywork while under the influence of alcohol or recreational drugs is potentially harmful, I attest to not being under the influence of either alcohol or recreational drugs while receiving my services.
~ It is understood that the services I receive are strictly therapeutic and non-sexual in intent. Sexually-oriented or threatening behavior by me may cause the session to be terminated, at which time I agree to make full payment for my service.
~ I understand that I may discontinue the session(s) if for any reason that I feel uncomfortable.
~ I understand that I am financially responsible for my appointments, and that payment is due at the time of service, unless otherwise arranged in advance.

In order to avoid full charges, I agree to give 24 hour notice of cancellation.

_____ **Date:** _____
Client's Signature

<u>Consent to Treatment of Minor</u>:
By my signature below I authorize St Johns Wellness Center, LLC, to administer therapeutic bodywork to my child or dependent, _____, as she deems necessary.

_____ **Date:** _____
Signature of Parent/Guardian