PHILADELPHIA — NEW YORK CITY

CLIENT INTAKE FORM:

Name____ Today's Date____________

Address______________________________City___________State________Zipcode______

Phone_________________________ (cell)   Date of Birth __________

Occupation______________________

Emergency Contact__________________Phone________________Relationship__________

Referred by__________________Email address: __________________________________.

Would you like to receive our email newsletter? Y_____ N_____

What is your goal for today's session? ____.

Where are you holding tension in your body? ______________ ______________________.

Please list any surgeries, injuries, accidents or hospitalizations you have had:

Less than 5 years ago: ____.

More than 5 years ago: ____.

What kind of care did you receive for your injuries? ___________________________________.

Do you feel that you have recovered from these events? _______________________________

____.

Do you have any chronic, ongoing pain? Where? ____________________________________.

What activities make the pain worse? ____.

Are you receiving any other type of medical treatment? _______________________________.

Please list any medications, herbs, supplements you are currently using___________________

____.

Are you under the care of a physician? ______Whom/Why? ___________________________

____.

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Circle any of the following conditions that affect you now, or that you've had in the last 5 years.

Musculoskeletal
Fibromyalgia
Spasms/Cramps
Sprains/Strains
Osteoporosis
Osteoarthritis
TMJ
Bursitis
Rheumatoid Arthritis
Tendonitis
Whiplash
Carpal Tunnel
Sciatica
Neck pain
Back pain Mid/Low
Headaches/Migraines
Leg Pain
Arm/Shoulder Pain
Hip Pain
Thoracic Outlet
Other_____

Circulatory
Anemia
Hypertension
Low Blood Pressure
Raynaud's
Varicose Veins
Heart Condition
Blood Clot
Diabetes
Other_____

Nervous
ALS
MS
Parkinson's
Bell's Palsy
Neuritis
Brain/Spine Injury
Concussion
Seizure Disorders
Numbness/Tingling
Other_______

Digestive
Ulcers
IBS
Colitis
Gallstones
Hepatitis A/B/C
Stroke
Trigeminal Neuralgia
Crohn's
Diarrhea/Constipation
Gas/Bloating
Food Allergies
Indigestion
Other__________

Respiratory
Pneumonia
Sinusitis
Asthma
Breathing Difficulty
Bronchitis
Emphysema
Other______

Other
Insomnia
Anxiety/Panic Attacks
PMS
Grief Process
Lyme Disease
Cancer
Chronic Fatigue
Pregnancy
Lupus
HIV/AIDS
Edema
Liposuction
Postoperative Situation
Other__________

Medical Disclaimer
I, the undersigned, understand that the licensed massage therapy treatment provided by Ula Katsoulis, is not meant to replace medical care and consultation. I agree that if I have a serious medical condition, I will consult my physician.

Date: _________________________

Print Name:_______________________

Signature:____

PHILADELPHIA — NEW YORK CITY

Stillpoint Holistic Studio Client-Facilitator Agreement

CONSENT FOR CARE AND TREATMENT

As your licensed massage therapist, I will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of techniques may be used. I, the undersigned, do hereby agree and hereby give my consent for Ula Katsoulis to furnish massage therapy and treatment considered necessary and proper in treating my physical condition.
Initials________

CANCELLATION / NO SHOW POLICY

All appointments are scheduled on a per client basis. A minimum of 24 hours notice is required for cancellation. Cancellations made less than 24 hours or no show appointments, will be charged the full session fee.
Initials_________

PAYMENT

Payment is expected at time of treatment or prior to if appointment is scheduled online. You may pay with cash, check, MasterCard or Visa. Please make checks payable to Stillpoint Holistic Studio. There is a $25 service fee charge for all returned checks.
Initials________

INSURANCE

I am an independent licensed massage therapist and do not bill private insurance, Workman’s Compensation, or Medicare. However, I will provide you with the necessary information so that you may submit the claim to your insurance carrier. Please contact your insurance carrier to verify the limits of your coverage.
Initials__________