Personal Information

Client Contact Information

First name *

Enter your first name

Last name *

Enter your last name

Phone Number *

+1 (___) ___-_____

Email *

example@example.com

Birth date *

Select month

Select day

Select year

Street address

Enter street address

City

Enter city

State

Enter state

Zip code

Enter zip code

Emergency Contact Information

Contact Name

Phone Number

Doctor Contact Information (optional)

Doctor's Name

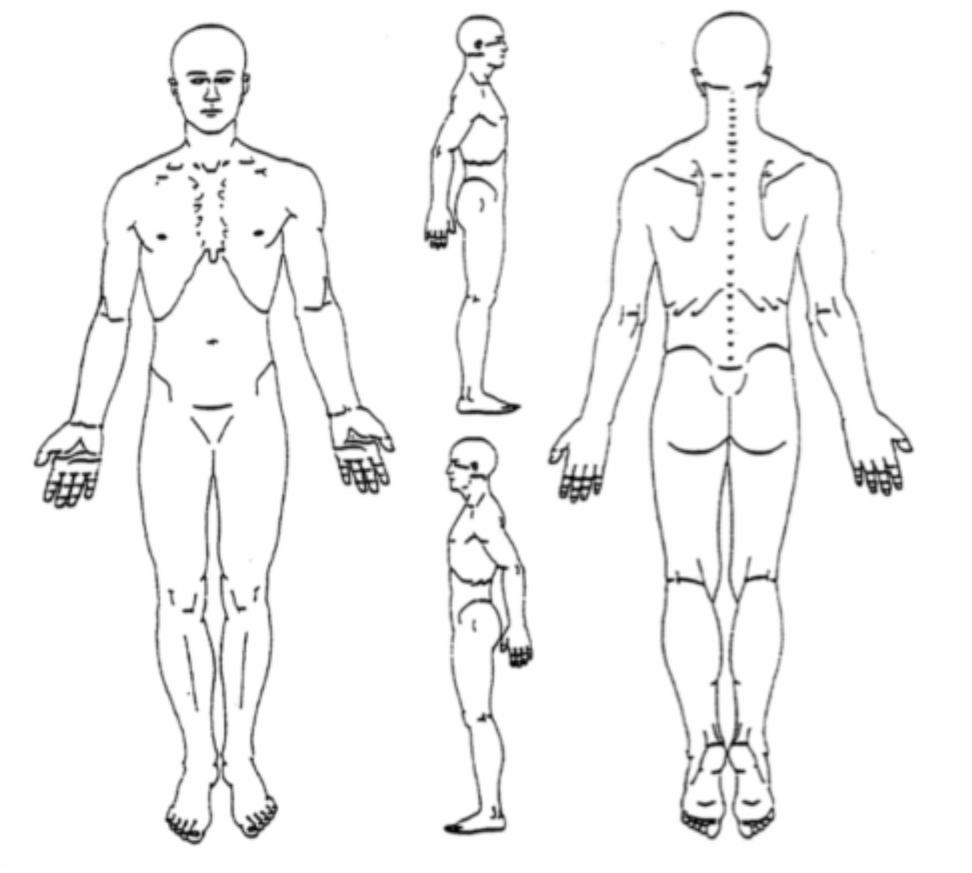
Phone Number

How did you hear about us?

Issues to Address

Issues to Address

Click or tap the area(s) in question and describe sensation(s) i.e. tight, sharp pain, sore, bruising, dull ache, etc.



Cause of injury or concern

How long since first noticed

Treatment Goals

Past treatments

Existing Conditions

COVID-19 SYMPTOMS

Please check the box below if any of the following are true:

- Have had a fever within the last 24 hours
- Recently experienced respiratory/flu symptoms, sore throat, or shortness of breath
- Contact, within the last 14 days, with anyone diagnosed with COVID or related symptoms

- [ ] COVID Symptoms Questionnaire

RESPIRATORY

- [ ] Asthma
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Shortness of Breath
- [ ] Chronic Cough

CARDIOVASCULAR

- [ ] Blood Clots
- [ ] High Blood Pressure
- [ ] Varicose Veins
- [ ] Congestive Heart Failure
- [ ] Phlebitis
- [ ] Heart Attack
- [ ] Lymphedema
- [ ] Cold Hands
- [ ] Pacemaker
- [ ] Cardiovascular Accident
- [ ] Low Blood Pressure
- [ ] Cerebral-vascular Accident
- [ ] Stroke
- [ ] Cold Feet

- [ ] Heart Disease
- [ ] Thrombosis/Embolism
- [ ] Myocardial Infarction
- [ ] Hemophilia

SKIN

- [ ] Bruise Easily
- [ ] Skin Irritations
- [ ] Hypersensitive Reaction
- [ ] Melanoma
- [ ] Other Skin Conditions

HEAD & NECK

- [ ] Ear Problems
- [ ] Migranes
- [ ] Headaches
- [ ] Sinus Problems
- [ ] Hearing Loss
- [ ] Vision Loss
- [ ] Jaw Pain (TMJD)
- [ ] Vision Problems

INFECTIOUS CONDITIONS

- [ ] Athlete's Foot
- [ ] Respiratory Conditions
- [ ] Hepatitus
- [ ] Skin Conditions
- [ ] Herpes
- [ ] HIV

REPRODUCTIVE

- [ ] Gynecological Issues
- [ ] Pregnancy

FAMILY HISTORY

- [ ] Cardiovascular Conditions
- [ ] Respiratory Conditions

NEUROLOGICAL

- [ ] Burning
- [ ] Numbness
- [ ] Tingling
- [ ] Stabbing Pain

- [ ] Cerebral Palsy
- [ ] Parkinsons
- [ ] Multiple Sclerosis
- [ ] Herniated Disc
- [ ] Epilepsy

OTHER PHYSICAL CONDITIONS

- [ ] Allergies
- [ ] Osteoporosis
- [ ] Dizziness
- [ ] Diabetes
- [ ] Anaphylaxis
- [ ] Surgical Pins or Wire
- [ ] Arthritis
- [ ] Crohn's Disease
- [ ] Osteoarthritis
- [ ] Artificial Joints/Special Equipment
- [ ] Rheumatoid Arthritis
- [ ] Loss of Sensation
- [ ] Gout
- [ ] Fibromyalgia
- [ ] Lupus
- [ ] Digestive Conditions
- [ ] Other Diagnosed Diseases
- [ ] Shingles
- [ ] Other Medical Conditions
- [ ] Cancer

OTHER MENTAL/EMOTIONAL CONDITIONS

- [ ] Stress
- [ ] Insomnia
- [ ] Mental Illness
- [ ] Anxiety
- [ ] Social anxiety
- [ ] Chronic worry
- [ ] Depression
- [ ] Unhealthy habits
- [ ] Boundary Management
- [ ] Spiritual Awakening
- [ ] Energy Management
- [ ] Burnout
- [ ] Negative behavior and patterns
- [ ] Trauma
- [ ] Abuse Recovery
- [ ] Life changes and transitions

PTSD

Phobia

ANYTHING ELSE?

Is there anything else that would be helpful for your therapist to know?

MEDICATIONS

Please list any medications or drugs you are currently on

Waiver

Therapeutic Massage and Bodywork Waiver Form

Please take a moment to read and initial the following information:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

Signature *

Sign above

I have read the statement above and agree to all the policies *

MM-DD-YYYY

BodyMind Bridge/Reiki Waiver

BodyMind Bridge and Reiki Healing Waiver Form

The services you receive from Sarah Schweizer are intended to be educational and provide helpful information and are not offered as a substitute for professional mental health care or medical care and are not intended to diagnose, treat or cure any mental health or medical conditions.

Sarah Schweizer is a Reiki Practitioner and Registered Hypnotherapist and does not provide any form of medical care or psychotherapy nor does she represent her services as any form of medical or mental health care.

While services offered may have beneficial effects, they are not a substitute for appropriate medical attention, and Sarah Schweizer makes no claims about the specific individual results that may occur or their permanency.

You are fully in charge of and responsible for your well-being in your session, including your choices and decisions during and after.

Sarah Schweizer will protect your information as confidential unless you state otherwise in writing. In addition, if you report abuse or threaten to harm yourself or someone else, your confidentiality agreement is limited in this capacity. Further, the use of technology may not always be secure and you accept the risks of confidentiality in the use of email, text, phone, Zoom, and other technology.

Please consult a trusted healthcare provider, a qualified physician or therapist when dealing with or seeking guidance about any physical and/or mental illness or disease, before making any healthcare decisions.

Signature *

Signature

By signing above I indicate that I understand and agree to the above terms

Date

MM-DD-YYYY