Client Intake Form

Sensoma Body Wellness

Today's Date: _____ Referred by: _____

Name: _____ Age: _____ Cell/Text: _____

Email: _____ Emerg. Name/Number: _____

Reason for visit today: _____

Have you had plastic surgery or other similar bodywork? _____ Date(s): _____

Name of Facility and Surgeon(s): _____

List everything you had done: _____

Check any condition listed below that applies to you:

- ☐ Acute or Contagious Illness (NO TREATMENT)
- ☐ Acute Hernia (V, W)
- ☐ Acute Inflammation (area: _____)
- ☐ Acute Injury (area: _____)
- ☐ Adhesive Sensitivity (T)
- ☐ Allergic Dermatitis (area: _____)
- ☐ Ascites (NO TREATMENT)
- ☐ Autoimmune Disease (CA)
- ☐ Blood Clots (NO TREATMENT)
- ☐ Blood Thinner Meds (G, FG)
- ☐ Body Piercings (area: _____)
- ☐ Bruise Easily (G5, G, W)
- ☐ Cancer (NO TREATMENT)
- ☐ Cardiac Disease or Condition (CA)
- ☐ CBD Sensitivity (C)
- ☐ Cellulitis (NO TREATMENT)
- ☐ Chemotherapy (NO TREATMENT)
- ☐ COVID19 (NO TREATMENT)
- ☐ Dermatosis (area: _____)
- ☐ Diabetic (MC, S, V)
- ☐ Eczema (area: _____)
- ☐ Embedded Metal Object (RF, L, CA, V)
- ☐ Enzyme intake (SB)
- ☐ Epileptic (RF, L, CA, V, G5, V)
- ☐ Fever (NO TREATMENT)
- ☐ Fresh Cuts (area: _____)
- ☐ Fresh Tattoos (area: _____) (SB)
- ☐ HIV, AIDS (CA)
- ☐ Hypotension (V, G5)
- ☐ Heart Problems uncontrolled (NO TREATMENT)
- ☐ Hemorrhagic Disease or Condition (MC, SB)
- ☐ High Blood Pressure uncontrolled (NO TREATMENT)
- ☐ Implants-any (B, RF, L, CA, V, FG) (area: _____)
- ☐ Infection untreated (SB)
- ☐ Injections (area: _____)
- ☐ IUD Device (CA)
- ☐ Joint Implant (V)
- ☐ Kidney Disease/Failure (MLD ONLY)
- ☐ Lactation (B, RF, L, CA)
- ☐ Latex
- ☐ Liver Failure or Disease (RF, L, CA)
- ☐ Lymph nodes removed
- ☐ Malignancy (NO TREATMENT)
- ☐ Menses (RF, L, CA, G5)
- ☐ Multiple Sclerosis (SB)
- ☐ Neurological Condition (CA)
- ☐ Nursing (CA, BL)
- ☐ Oils, Creams or Gels (type: _____
- ☐ Pacemaker or Electronic Device (CA)
- ☐ Phlebitis (CA)
- ☐ Plastic or Bone Cement (CA)
- ☐ Polyurethane Sensitivity (F)
- ☐ Pregnant (MLD ONLY)
- ☐ Psoriasis (area: _____)
- ☐ Pulmonary Embolism (V)
- ☐ Rashes (area: _____)
- ☐ Recent Fracture (area: _____) (SB)
- ☐ Recently placed IUD or pins (V)
- ☐ Retinal Condition (V)
- ☐ Rheumatoid Arthritis (V)
- ☐ Shortness of Breath (SB)
- ☐ Silicone (BL)
- ☐ Severe Edema (MC)
- ☐ Severe Migraines (V)
- ☐ Stroke or Aneurysm (FG)
- ☐ Sunburn (area: _____)
- ☐ Surgery (area: _____) (SB)
- ☐ Thrombosis (NO TREATMENT)
- ☐ Transplant (CA)
- ☐ Tuberculosis (CA)
- ☐ Vascular Disease or Condition (CA)
- ☐ Zinc or Nickel Allergies (CA)

B=Breast Lift, C=CBD, CA=Cavitation, F=Foam Sheets, G=Gua Sha, G5=G5, L=Laser Lipo, M=MLD, MC=MediCupping, O=Oils, R=RF, S=SkinBrushing, T=Taping, V=Vibration, W=Wood Therapy, SB=Sauna Blanket, FG=Fascia Gun

Please note that certain medical conditions are contraindicated and determine if and when you can receive a service. After the consultation and review of the information provided on this form, it will be determined if services should be administered today. Some conditions will require a note from your doctor before proceeding. Please understand this is for your safety and wellbeing.

Have you had any of the following symptoms in the last 2 weeks:

__ Fever	__ Chills	__ Cough
__ Sore throat	__ Diarrhea, digestive upset	__ Nasal/sinus congestion
__ Loss of taste or smell	__ Fatigue	__ Shortness of breath
__ Rash or skin lesions	__ Sudden onset of muscle soreness	

I understand that my name and contact information might be shared with the state health department in the event that a client or Practitioner tests positive for COVID-19. Contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

I understand that close contact with people increases the risk of infection from COVID19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive treatment from this Practitioner.

Is there is anything else the Practitioner should know about you or your needs before the session?

_____

_____

I further understand that massage or bodywork should not be construed as a substitute for a medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that Practitioners are 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 bodywork 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 the Practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the Practitioner's part should I fail to do so.

Initial any that apply:

_____ Do not take, use or text any pictures.

_____ I agree to pictures or videos being used for progress and marketing purposes (Instagram & Facebook).

_____ I agree to pictures being used for progress purposes only, no marketing.

_____ Text pictures to the cell # on file.

Signature: _____ Date _____