Client Information Intake Form

Higher Mind Healing expects payment at time of service. Cash, check or credit card is accepted.

Date _____

Name_____

Address_____

City_____State_____Zip_____

Date of Birth_____Age_____Occupation_____

Cell Phone _____Home Phone _____

Work Phone _____Referred by _____

Email Address (for the purpose of informing and communicating with clients only)
_____

Emergency contact_____Phone_____Relationship_____

What are your goals for this therapy?

What are the repetitive postures/motions that you perform at work/other setting?

What are your exercise activities?

Please list any current medications and their purposes:

Informed Consent and Agreement

It is my choice to receive massage, Prana healing, *LED Light Sessions* or other modality. I understand that the session is intended for relaxation, muscle tension release, increased range of motion, improved circulation, reduced stress, increased energy flow and balance, plus a positive experience.

I understand that massage/*light sessions*/healing sessions are not a substitute for medical treatment, examination, or medications. It is recommended that I concurrently work with my primary caregiver or specialist for any condition that I may have. I have informed the massage practitioner/Quantum Light Energy Coach of all my known physical and medical conditions and medications. I will keep her updated on any changes in my health status. I understand that all information regarding my health history, the records of my sessions, and other personal information related to the session will remain in complete confidence. If this information is requested, I will release it under written consent (HIPAA law).

I will follow the **24-hour cancellation policy** via phone or I will need to pay the full amount for the service scheduled (emergency situations excepted).
Please be on time. Thank you.

Signature _____ **Date** _____

Medical History

Please check all that apply to you
(Specify whether Current or Previous)

Muscular-Skeletal

____Headaches
____Joint stiffness/swelling
____Broken/Fractured Bones
____Strains/Sprains
____TMJ Dysfunction
____Tendonitis
____Bursitis
____Sciatica

Digestive

____Diverticulosis
____Irritable Bowel Syndrome
____Crohn's Disease
____Colitis
____Adaptive Aids
____Diabetes
____Other_____

____Arthritis
____Osteoporosis
____Scoliosis
____Shoulder dislocation
____Whiplash
____Knee surgery
____Hip replacement
____Thoracic Outlet Syndrome
____Disc herniation
____Other_____

Other

____HIV
____Fibromyalgia
____Hearing impaired
____Visually impaired
____Drug use_____
____Infectious disease_____
____Depression_____
____Other_____

Nervous System

____Numbness/Tingling
____Sleep disorders
____Cerebral Palsy
____*Epilepsy**
____*Seizures**
____Chronic Fatigue
____Parkinson's Disease
____Spinal cord injury
____Carpal Tunnel Syndrome
____Other_____

Reproductive

____*Pregnancy***
____Cesarean Section
____Menopause
____Pelvic Inflammation Disorder
____Endometriosis
____Hysterectomy
____Other_____

Circulatory/Respiratory

____Dizziness/Fainting
____Varicose veins
____Blood clots
____Stroke
____Heart condition
____Allergies
____Asthma
____Low/High blood pressure
____Other_____

Surgeries Date

_____

_____

_____

_____

The information provided above is accurate to the best of my knowledge.

Signature_____ **Date**_____

** If these conditions are present, the light session eye mask is not used on the eyes but can be placed safely elsewhere on the body. ** Consult with your OB/Gyn.*