



## HOLISTIC THERAPY CLIENT INFORMATION FORM

Please be assured that the information requested below will be treated in the strictest confidence and is for the purpose of ensuring your safety and comfort and to ensure the chosen therapy is suitable for you

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Please tick if you object to being added to our mailing list for special offers and newsletters.

DOB: \_\_\_\_\_ Gender: M / F

Occupation: \_\_\_\_\_

Emergency Contact (name & phone number):  
\_\_\_\_\_

Please confirm which therapies you are interested in: -

- Angel Healing Therapy
- Aromatherapy Massage
- Crystal Therapy
- Indian Head Massage
- Life Coaching
- Meditation
- Reflexology
- Reiki
- Stress Management

How did you find out about Rocks n Rituals?  
\_\_\_\_\_

**The following information will be used to help plan safe and effective massage/holistic therapy sessions.**

**Please answer the questions to the best of your knowledge.**

Date of Initial Visit: \_\_\_\_\_

1. Have you had alternative therapies before? Yes/No

If yes, how often do you receive alternative therapies? \_\_\_\_\_

2. Do you have any difficulty lying on your front, back, or side? Yes/No

If yes, please explain \_\_\_\_\_

3. Do you have any allergies to oils, lotions, or ointments? Yes/No

If yes, please explain \_\_\_\_\_

4. Do you have sensitive skin? Yes/No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?

6. Do you sit for long hours at a workstation, computer, or driving? Yes/No

If yes, please describe \_\_\_\_\_

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes/No

If yes, please describe \_\_\_\_\_

8. Do you experience stress in your work, family, or other aspect of your life? Yes/No

If yes, how do you think it has affected your health?

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other: \_\_\_\_\_

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes/No

If yes, please identify \_\_\_\_\_

10. Do you have any particular goals in mind for this session? Yes/No

If yes, please detail \_\_\_\_\_

---

---

---

---

---

---

---

---

## Medical History

In order to plan a massage/holistic therapy session that is safe and effective I need some general information about your medical history.

11. Are you currently under medical supervision? Yes/No

If yes, please explain: \_\_\_\_\_

Doctor's Name/Practice: \_\_\_\_\_

12. Do you see a chiropractor? Yes/No

13. Are you currently taking any medication? Yes/No

If yes, please list

14. Please check any condition listed below that applies to you:

- |  |  |
|--|--|
| <input type="checkbox"/> contagious skin condition                                     | <input type="checkbox"/> diabetes                                  |
| <input type="checkbox"/> open sores or wounds  | <input type="checkbox"/> swollen glands                            |
| <input type="checkbox"/> deep vein thrombosis/blood clots                              | <input type="checkbox"/> decreased sensation                       |
| <input type="checkbox"/> phlebitis   | <input type="checkbox"/> allergies/sensitivity                     |
| <input type="checkbox"/> easy bruising   | <input type="checkbox"/> back/neck problems                        |
| <input type="checkbox"/> recent accident or injury                                     | <input type="checkbox"/> heart condition                           |
| <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis | <input type="checkbox"/> Fibromyalgia                              |
| <input type="checkbox"/> recent fracture   | <input type="checkbox"/> high or low blood pressure                |
| <input type="checkbox"/> osteoporosis  | <input type="checkbox"/> TMJ                                       |
| <input type="checkbox"/> recent surgery  | <input type="checkbox"/> circulatory disorder                      |
| <input type="checkbox"/> epilepsy  | <input type="checkbox"/> carpal tunnel syndrome                    |
| <input type="checkbox"/> artificial joint  | <input type="checkbox"/> varicose veins                            |
| <input type="checkbox"/> headaches/migraines   | <input type="checkbox"/> tennis elbow                              |
| <input type="checkbox"/> sprains/strains   | <input type="checkbox"/> atherosclerosis                           |
| <input type="checkbox"/> cancer  | <input type="checkbox"/> pregnancy <u>If</u> yes, how many months? |
| <input type="checkbox"/> current fever   |  |

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? Yes/No

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**CLIENT RELEASE & CONSENT FOR TREATMENT**

***Please read carefully and sign below.***

- I understand that the massage/bodywork I receive is provided for the **basic purpose of relaxation and relief of muscular tension.**
- Techniques may include Aromatherapy Massage, Reflexology Massage, Chakra Balancing, Crystal Therapy, Angel Healing, Meditation and/or Reiki.
- Modest draping will be provided.
- During the full body massage treatments **head, back, neck area, arms, legs** will be addressed **and treatment will be performed on the relevant parts of the body only**, excluding breast/chest and genital areas.
- If I experience any pain or discomfort during treatment, I will immediately inform the therapist so that pressure and/or strokes may be adjusted to my level of comfort. I also, may request that the session discontinued at any time, for any reason, and the therapist will honour that request.
- I further understand that massage or holistic treatment of any kind **should not be considered as a substitute for medical examination, diagnosis or treatment** and that I should see a physician, chiropractor or other qualified specialist for any mental or physical ailment of which I am aware.
- I understand that massage therapists 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 considered as such.
- I understand that because massage/holistic therapies 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 therapist updated of any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.
- I consent to receiving \*angel healing therapy, aromatherapy, Indian head massage, life coaching, stress management counselling, meditation, reflexology, crystal therapy and/or Reiki. **\* Please delete as applicable if you do not consent to any particular therapy.**
- I hereby indemnify Rocks n Rituals and the therapist against any adverse reaction sustained as a result of the treatment.

Client Signature \_\_\_\_\_

Date\_\_\_\_\_

**Therapist Confirmation**

All information provided on this form shall be kept confidential and used solely for the purpose of the holistic therapies provided. Full details of the proposed treatment have been given to the client and their consent to same is given. Qualification certificates, membership body certificates and insurance certificates can be provided upon request.

Therapist Signature \_\_\_\_\_

Date\_\_\_\_\_