LIVING WELL DALLAS | 14330 MIDWAY RD, SUITE 121, DALLAS, TX 75244 | 972-930-0260

First Name:	Last Name:	Date of Birth:
Prefer to be Called:	Marital Status (Circle): Single Married Partnered Widowed Separated	Age:
Street Address:	City:	State: Zip:
Preferred Phone (Circle): home work cell	Alternate Phone: home work cell	May we leave a message on your preferred phone? ○Yes ○No
Employer:	Occupation:	SS#
Emergency Contact Name: Emergency Phone(s):	Preferred email:	Primary Care Physician:
List any drug allergies:	Preferred Pharmacy:	List any food allergies:

What is your main reason for your visit today?

Which Services Interest You:

- ○ acupuncture
- ○ aromatherapy
- ○ Biofeedback
- ○ bio-identical hormones
- ○ Bowen technique
- ○ Chiropractic
- ○ craniosacral therapy
- ○ counseling/therapy
- ○ detox program
- ○ energy medicine
- ○ energy medicine
- ○ emotional freedom technique
- ○ frequency specific microcurrent
- ○ functional medicine
- ○ food allergies testing
- ○ health coaching
- ○ Healing Touch™
- ○ HeartMath™
- ○ life coaching
- ○ massage
- ○ men's health
- ○ nutritional testing
- ○ metabolic blueprint
- ○ nutrition counseling
- ○ organization
- ○ rapid eye technology
- ○ Reiki
- ○ walk & talk therapy
- ○ wellness
- ○ weight loss

Would you like to receive our newsletter? ○**Yes** ○**No** *(we will never sell your name)*

Cancellation & Re-Scheduling Policy

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

Please know that all cancellations and/or rescheduling requests must be made at least two business days prior to the date of your appointment. If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be "missed" and charged for the full session fee. Thank you for your understanding.

( ) **I understand and accept this policy**

_____ _____

Your Signature **Today's Date**

Records and Privacy Policy: We will not release your records to anyone without your written consent. Because this is an integrated practice with multiple practitioners, we may facilitate care by having only one record per client. Coordinated care by your chosen practitioners will always be done with respect for your personal privacy and confidentiality.

( ) I understand and accept this policy

_____ _____

Your Signature **Today's Date**

LIVING WELL
:health & wellness center:

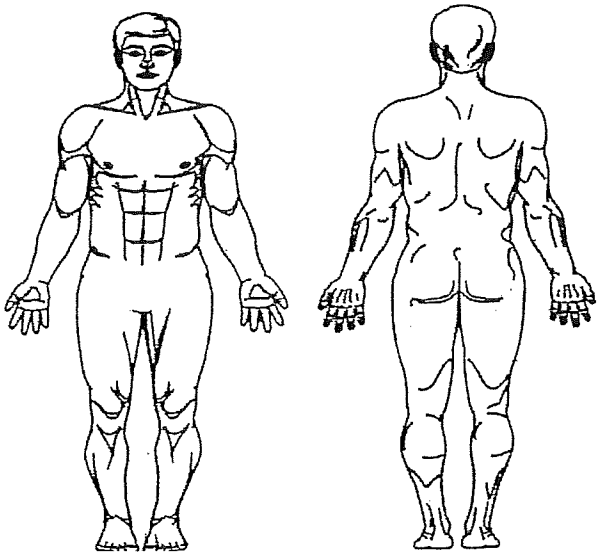
MASSAGE INTAKE

Name: _____ Referred by: _____

Please answer the following questions with "YES" or "NO". Explain if necessary.

Skin problems	_____	Arthritis	_____	High/Low blood pressure	_____
Blood clots	_____	Diabetes	_____	Varicose veins	_____
Seizures	_____	Pregnant	_____	Circulation disorders	_____
Contact lenses	_____	Cancer	_____	Contagious diseases	_____

On this diagram, please **circle** the areas of the body that you feel need the **most** attention during this massage session. Also, place an **"x"** over the areas that you wish the therapist to **avoid**:



Please initial the following statements:

1. I am aware that draping will be used during the massage session. _____
2. I understand that it is not within the scope of the massage session for the therapist to engage in breast massage of female clients, without written consent. _____
3. I understand that my feedback is an essential element in my treatment, therefore if at any time I should become uncomfortable during the massage, I may bring it to the attention of the massage therapist and request for the session to end. _____
4. If I am unable to keep an appointment, I understand that a 24 hour notice is required, otherwise, I will be charged for the time reserved. _____

Please read the following statements, and then sign at the bottom of the page:

- I have read and I fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist, and update this form before receiving additional massages.
- The massage treatment given here is for the sole purpose of stress reduction, relief from tension or spasm and to increase circulation and energy flow.
- The Massage Therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder.
- The Massage Therapist does not do spinal manipulations. Massage Therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you may have.
- It is the Client's (your) responsibility to explain and discuss all physical conditions with the Massage Therapist so that they may do their job. Your massage Therapist is an independent professional and is solely responsible for your treatment.

_____ _____

Client Signature Massage Therapist Signature