

Ritual Self Care
314 Clifton Avenue
Carriage House
612.280.3000 / www.ritualselfcare.earth

NEW CLIENT INTAKE FORM

Personal Information

Name _____ Date _____

Email Address _____

Phone _____ Birthday _____

Emergency contact: Name _____

Phone number _____

Referred by _____

Your current or past occupation _____

What are your most important self care practices? _____

What hobbies do you enjoy? _____

How is your sleep? _____

How many hours do you typically sleep each night? _____

What is your usual physical activity? _____

Specific Concerns

What are your expectations of the service you are receiving today? _____

Do you have areas of pain and / or concern? NO YES - Describe _____

Women : Are you or might you be pregnant? NO YES / Weeks

Do you have a history of cancer? NO YES If yes, please answer the following:

Type _____

Chemotherapy? NO YES, type _____

When? _____ Completed? _____

Radiation therapy? NO YES, where? _____

When? _____ Completed? _____ Radiation burns? _____

Surgery? NO YES, where? _____

Lymph nodes removed? NO YES, where and how many? _____

Lymphedema? NO YES, location / side _____

Are current blood counts a concern? NO YES : If yes, describe _____

Medical History - For Everyone

Are you currently under the care of a doctor or other health care practitioner? NO YES

If so, for what condition? _____

List all diagnoses: _____

Name of practitioner/clinic _____

City _____ State _____ Phone _____

List all medications you are taking: _____

List all supplements you are taking: _____

Allergies: _____

Previous broken bones including year: _____

Previous accidents including year: _____

Previous surgeries including year: _____

Other hospitalizations including year: _____

Do you currently have:

Acute inflammation - caused by an antigen - bacteria, viruses or poisons? NO YES

Acute Phlebitis - inflammation of the vein, past or present? NO YES

Acute Thrombosis, past or present? NO YES

Congestive heart problems, past or present? NO YES

If yes to any of the above, please explain:

Is there anything else you would like me to know? _____

Skin Care Questions - if you are getting a facial :

What 3 things do you love about your skin?

What 3 things would you like to change about your skin?

Do you currently or have you used or had:

Do you use Retin-A, Renova / vitamin A derivative products ? Adapalene Hydroxyl Acid,
Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? NO YES
Botox, Juvederm, or another injectable? NO YES

Acne medication? NO YES, when? _____ Which drug? _____

Chemical peel or microdermabrasion? NO YES

Tanning bed? NO YES

Have you used these products in the last 3 months? NO YES _____

If YES to any of these, please explain:

Have you ever experienced claustrophobia? NO YES

Do you have any known allergies to anything you have used on your skin? NO YES,
describe: _____

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

rash

irritation

peeling

sun sensitivity

breakout

Other / explain: _____

Have you had cosmetic surgery? NO YES, describe: _____

What products are you currently using on your skin? List brand and circle **S for satisfied** and **U for unsatisfied**.

Cleanser S / U _____ Toner S / U _____

Moisturizer S / U _____ Sunscreen S / U _____

Mask S / U _____ Foundation/ makeup S / U _____

PURPOSE AND LIMITATIONS OF BODYWORK:

I, _____ (name), understand that payment is due at the time of treatment unless arrangements have been made otherwise. I agree to give at least 48 hours notice of cancellation of an appointment and I understand that if I give less than 48 hours notice I may be charged the full amount of the appointment booked.

I understand that professional bodywork is for the purpose of stress reduction, relief from muscular tension, general relaxation, improvement of joint mobility and improvement of circulation. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and / or strokes may be adjusted to my level of comfort. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment, pharmaceuticals or perform spinal manipulations. I understand that bodywork is not a substitute for medical treatment, and it is recommended that I see a physician for any

physical ailment I might have. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.

I have read and understand the Complementary and Alternative Health Care Client Bill of Rights that has been provided to me.

LIABILITY RELEASE:

I agree to release, save, hold harmless and indemnify Nissa Valdez and Ritual Self Care LLC, its officers and directors from and against any future claims, demands or legal actions arising out of any session I receive at or through Ritual Self Care LLC. I specifically understand that I am agreeing that neither I nor my family will make any future claims or demands on and further not to sue or take legal actions against my therapist nor against Ritual Self Care LLC, its officers or directors for negligence, strict liability, malpractice, breach of contract or for any other legal cause of action which may arise from any session I receive through Ritual Self Care LLC.

By signing this document I am stating the following: (1) I am able to read, understand and comprehend the English language; (2) I have carefully read the provisions contained in this document; (3) I understand, comprehend and agree to the provisions contained in this document.

Client's Printed Name _____

Client's Signature _____ **Date** _____

Parent / Guardian Signature if client is under 18 years old
