SoulFire Healing Arts

One spark, igniting one passion, can light the world.

Personal Information

Name _____ email _____
Phone (Cell) _____ Phone (Home) _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Occupation _____
Primary Care Physician_____ Phone _____
Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective sessions today and in the future. It will be kept entirely confidential. Please answer all questions to the best of your knowledge. If you have any questions, please ask your therapist.

Date of Initial Visit _____

1. Have you had professional body or energy work before? Yes ☐ No ☐
   If yes, how often? _____
   If yes, what types of work have you experienced? _____
2. Do you have any difficulty lying on your stomach, back, or side? Yes ☐ No ☐
   If yes, please explain _____
3. Do you have any allergies or sensitivities to oils, lotions, or ointments? Yes ☐ No ☐
   If yes, please explain _____
4. Do you have sensitive skin? Yes ☐ No ☐
5. Do you wear:
   ☐ contact lenses ☐ dentures
   ☐ hearing aids ☐ a wig or hair extensions
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 any work, sport, or hobby? Yes ☐ No ☐
   If yes, please describe _____
8. Do you experience stress in your work, family, or other aspects 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 an area of the body where you are experiencing tension, stiffness, pain or discomfort? Yes ☐ No ☐
   If yes, please identify _____
10. Do you have any specific goals in mind for this session? Yes ☐ No ☐
    If yes, please explain _____

Medical History

11. Are you currently under medical supervision? Yes ☐ No ☐
    If yes, please explain _____
12. Do you see a chiropractor? Yes ☐ No ☐
    If yes, how often? _____
13. Please check any condition listed below that applies to you:

Respiratory:

- ☐ asthma
- ☐ shortness of breath
- ☐ bronchitis
- ☐ emphysema
- ☐ chronic cough

Cardiovascular:

- ☐ blood clots or deep vein thrombosis (DVT)
- ☐ phlebitis
- ☐ cerebralvascular accident (stroke)
- ☐ congestive heart failure (CHF)
- ☐ heart disease
- ☐ myocardial infarction (heart attack)
- ☐ cold hands/feet
- ☐ lymphedema
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ varicose veins
- ☐ atherosclerosis

Skin:

- ☐ bruise easily
- ☐ melanoma
- ☐ skin conditions
- ☐ skin irritations

Head, neck and neurological conditions:

- ☐ ear problems
- ☐ headaches
- ☐ migraines
- ☐ sinus problems
- ☐ hearing loss
- ☐ vision loss
- ☐ jaw pain (TMJD)
- ☐ vision problems
- ☐ burning pain
- ☐ tingling
- ☐ stabbing pain
- ☐ numbness/decreased sensation
- ☐ Cerebral Palsy
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ herniated disc
- ☐ epilepsy

Medical devices:

- ☐ pacemaker
- ☐ insulin pump
- ☐ colostomy or catheter bag

Infectious conditions:

- ☐ athlete's foot
- ☐ hepatitis
- ☐ fever or swollen glands
- ☐ herpes
- ☐ HIV/AIDS
- ☐ respiratory conditions

Miscellaneous:

- ☐ allergies/sensitivities
- ☐ artificial joint(s)
- ☐ surgical pins or wire
- ☐ cancer
- ☐ Crohn's Disease
- ☐ diabetes
- ☐ dizziness
- ☐ hemophilia
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ fibromyalgia
- ☐ osteoporosis
- ☐ gout
- ☐ shingles
- ☐ arthritis/osteoarthritis
- ☐ mental illness
- ☐ anxiety
- ☐ insomnia
- ☐ sprains or strains
- ☐ carpal tunnel syndrome
- ☐ thoracic outlet syndrome
- ☐ tennis elbow
- ☐ golfer's elbow
- ☐ tendonitis
- ☐ pregnancy
- ☐ recent accident or injury
- ☐ recent surgery

Please explain any condition that you have marked above _____

_____

_____

_____

14. Please list any medications you are taking whether prescribed, over the counter or self-medicating:

    _____
    _____
    _____
    _____
    _____

15. Is there anything else about your health history that would be useful for your practitioner to know to plan a safe and effective session for you? _____
    _____
    _____

Informed Consent

Draping will be used during massage sessions – only the area currently being worked on will be uncovered. You will be encouraged to dress down to your level of comfort. Polarity sessions are performed fully clothed. Are you comfortable with work being done on the following areas of the body:

scalp/head	Yes ☐ No ☐	face	Yes ☐ No ☐	neck	Yes ☐ No ☐
hands	Yes ☐ No ☐	arms	Yes ☐ No ☐	shoulders	Yes ☐ No ☐
chest	Yes ☐ No ☐	feet	Yes ☐ No ☐	legs	Yes ☐ No ☐
upper back	Yes ☐ No ☐	mid back	Yes ☐ No ☐	lower back	Yes ☐ No ☐
abdomen	Yes ☐ No ☐	gluteal region	Yes ☐ No ☐		

Please do not sign this form until you are in the presence of your therapist.

- I understand that massage and polarity therapy are provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- I understand that aromatherapy is a holistic science-art that utilizes concentrated plant extracts in the form of essential oils and hydrosols (aromatic waters), to bring harmony and balance to the body, mind and spirit.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care, but do complement most types of therapy. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, nor to diagnose, prescribe, or treat physical or mental illnesses.
- Because massage, polarity and aromatherapy should not be performed or used under certain medical conditions, I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I fail to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature. I understand that any illicit or sexually suggestive remarks or advances made by me will result in the immediate termination of the session without refund.
- I understand that my therapist reserves the right to deny services to anyone whom he/she deems to have a condition for which massage, polarity therapy or aromatherapy is contraindicated.

Signature of client: _____Date _____

Signature of parent or legal guardian:_____Date _____

Signature of therapist:_____ Date _____