

CLIENT INTAKE FORM

Sharon's Healing Arts

Do you know, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes No
Have you been in contact with anyone, in the last 14 days, who has been diagnosed with COVID-19? Yes No

Name: _____
Address: _____ City: _____ State: _____
E-mail: _____ Cell: _____ Work: _____
Occupation: _____ Emergency Contact Name/No: _____

So I can better support you, please describe what you want to receive from your session: _____

Briefly, describe your symptoms: _____

Have you experienced bodywork or energy work before? Yes No **If so, what did you like, or not like, about your experience?**

Favorite hobbies: _____

Briefly describe coping strategies you use when feeling stressed, (i.e., breath work, meditation, prayer, nature):

Sensitive to touch? Yes No **Sensitive to fragrance, essential oils?** Yes No

Medical Conditions - To provide you with an effective and safe treatment, please let me know:
Are you currently under the care of a physician? Yes No **If yes, Physician's name and number:**

Any surgeries or injuries? Any medical condition(s)? Medications? If so, please provide a brief summary. _____

Any head, spine, tailbone, (brain/spinal cord) injuries? Yes No **If yes, briefly describe:**

Women: Pregnant Yes No **Any high risk challenges?** _____

Release of Liability: I understand that bodywork/energy therapies (BW/ET) provided by Sharon's Healing Arts are not a substitute for medical treatment. I have indicated all of my known medical conditions. I will alert the therapist of any changes in my health status. It is my choice to receive BW/ET with an understanding of possible risks and benefits with no guarantee of effectiveness. I give my consent for treatment.

Cancellation and Payment Policies: Full payment is due at the time of service. A scheduled appointment means that time is reserved only for you. Late arrivals will not receive an extension of scheduled service time and will be responsible for the entire service fee. You will be responsible for the full payment if any appointment is missed or canceled with less than 24 hours' notice. If legal action is required to collect a payment, I agree to be responsible for legal fees and costs.

Client Signature _____ **Date:** _____