



**WHEAT RIDGE RECREATION CENTER**

**CLIENT INTAKE FORM**

(Please fill out and take form to first appointment with therapist)

**Offerings Include:**  **Massage**  **Reiki**

**Personal Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Day) \_\_\_\_\_ Evening: \_\_\_\_\_ Anytime(Cell): \_\_\_\_\_

Email address: \_\_\_\_\_ to be used for appt. reminders & follow-up, newsletters/announcements

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**The following information will be used to help plan safe and effective Massage/Reiki/Reflexology sessions. Please answer the questions to the best of your knowledge.**

Do you frequently suffer from stress?      Yes      No

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

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

Where do you hold your tension? \_\_\_\_\_

Do you exercise? Yes   No   What? \_\_\_\_\_ How Often? \_\_\_\_\_ How Long? \_\_\_\_\_

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

If so, please describe \_\_\_\_\_

Do you perform any repetitive movement in your work, sports, or hobby?

If so, please describe \_\_\_\_\_

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

Yes    No    If yes, please identify \_\_\_\_\_

Serious past illnesses? \_\_\_\_\_

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Accidents, injuries and dates? \_\_\_\_\_

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Hospitalizations and dates? \_\_\_\_\_

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Current prescriptions and for what conditions? \_\_\_\_\_

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Are you pregnant?    Yes    No    Due Date? \_\_\_\_\_

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

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

Do you suffer from arthritis?                      Yes                      No

Do you bruise easily?                      Yes                      No

Do you have any contagious diseases?                      Yes                      No

Do you suffer from epilepsy or seizures?                      Yes                      No

Do you suffer from joint swelling?                      Yes                      No

Do you have varicose veins?                      Yes                      No

Do you have osteoporosis?                      Yes                      No

Any broken bones in the past two years?                      Yes                      No

Are you wearing contact lenses?                      Yes                      No

Are you wearing dentures?                      Yes                      No

Do you feel you use the following excessively?

SUGAR    SMOKING    ALCOHOL    DRUGS    SALT    CAFFEINE    (circle all that apply)

Have you ever experienced a professional massage or bodywork session?    Yes    No    How recently? \_\_\_\_\_

What are your massage or bodywork goals? \_\_\_\_\_

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I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the wellness therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork wellness 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 construed as such. Because massage/bodywork 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 wellness therapist updated as to any changes in my medical profile and understand that there shall be no liability on the wellness therapist or City of Wheat Ridge's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

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

Date \_\_\_\_\_

**CITY OF WHEAT RIDGE  
PARKS & RECREATION DEPARTMENT  
WELLNESS WAIVER: RELEASE & CONSENT**

This is a consent and release of liability. Please read carefully before signing.

I, \_\_\_\_\_, have made a voluntary request to participate in a Wellness Therapy program at the City of Wheat Ridge Recreation Center and I do hereby agree to the following:

1. I acknowledge that I have been informed of the need to fill out a medical history and wellness goals form prior to beginning this program. I accept all responsibility for my health and any resultant injury or mishap that may affect my well-being or health in any way.
2. I freely, voluntarily and with such knowledge, assume the risk or risks associated with such wellness program. I take full responsibility for the ramifications of my actions and physical condition in connection with my participation in the wellness program. I understand that questions about wellness procedures and recommendations are encouraged and welcomed.
3. IN CONSIDERATION OF PARTICIPATING IN SAID WELLNESS PROGRAM, I RELEASE THE CITY OF WHEAT RIDGE, ITS OFFICIALS AND EMPLOYEES AND THEIR SURETIES, AND EACH OF THEM FROM ALL LIABILITY, CLAIMS, CAUSES OF ACTION, OR COSTS AND EXPENSES WHATSOEVER ARISING OUT OF ANY DAMAGE, LOSS OR INJURY TO ME OR MY PROPERTY INCURRED WHILE PARTICIPATING IN SAID WELLNESS PROGRAM, WHETHER SUCH LOSS, DAMAGE OR INJURY RESULTS FROM THE NEGLIGENCE OF THE CITY OF WHEAT RIDGE, ITS PUBLIC OFFICIALS AND EMPLOYEES AND THEIR SURETIES AND EACH OF THEM, OR FROM SOME OTHER CAUSE. I FURTHER RELEASE THE CITY OF WHEAT RIDGE, ITS OFFICIALS AND EMPLOYEES AND THEIR SURETIES FROM ANY LIABILITY OR CLAIMS OF ANY NATURE PERTAINING TO THE VOLUNTARY DISCLOSURE OF MY MEDICAL HISTORY.
4. I FURTHER AGREE FOR MYSELF, MY HEIRS, PERSONAL REPRESENTATIVES, EXECUTORS, ADMINISTRATORS AND ASSIGNS TO HOLD HARMLESS AND INDEMNIFY THE CITY OF WHEAT RIDGE, ITS PUBLIC OFFICIALS AND EMPLOYEES, THEIR SURETIES AND EACH OF THEM, AGAINST ANY AND ALL LIABILITY, CLAIMS, CAUSES OF ACTION, SUITS, DAMAGES OR EXPENSES OF EVERY KIND AND NATURE INCURRED OR ARISING BY REASON OF ANY ACTUAL OR CLAIMED NEGLIGENT OR WRONGFUL ACT OR OMISSION BY ME OR BY THEM WHILE PARTICIPATING IN SUCH WELLNESS PROGRAM.

I hereby represent that I have carefully read, understand and agree to the contents of this Release and Consent and sign the same voluntarily and of my own free will.

**CAUTION: READ THIS DOCUMENT IN FULL BEFORE SIGNING**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE (home) \_\_\_\_\_ (work) \_\_\_\_\_

**Contact in Emergency:**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

DATE \_\_\_\_\_

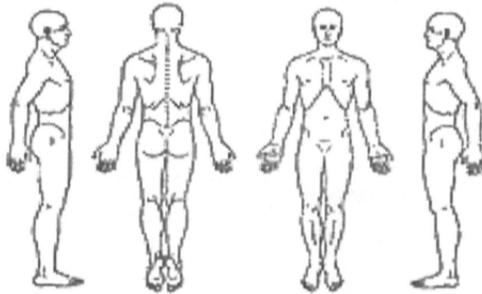
Signature: \_\_\_\_\_

(Adults 18 and Over)

Signature \_\_\_\_\_

(Parent/Guardian if under 18 Years of Age)

Please mark areas of concern/pain/discomfort on the chart below:



Other Specify:

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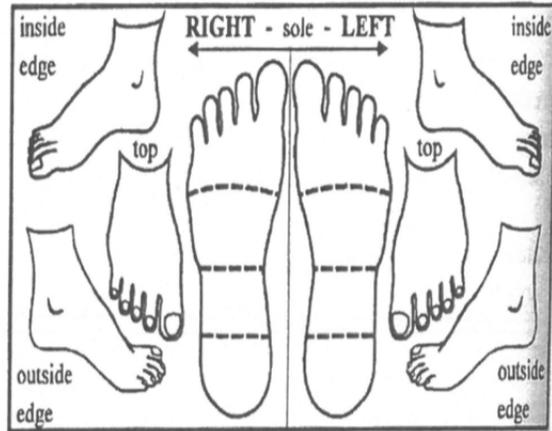
Reflexology only:

Foot Problems: \_\_\_\_\_ Describe: \_\_\_\_\_

\*Check any of the following that apply and mark on foot chart:

- |            |                           |
|------------|---------------------------|
| Corns      | Wart                      |
| Puffiness  | Bone Spur                 |
| Calluses   | Unusual color or rash     |
| Bunion     | Current injuries, bruises |
| Hammer Toe | Ingrown toenail           |
| Claw Toe   | Scars, past injuries      |

Other: \_\_\_\_\_



**Wellness Continuum**

Please mark where you think you fall on the Wellness Continuum

Sick

Your Optimum Health

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Getting sick

OK

Good

Is there anything else regarding your health history you think I should know about? If so, please elaborate:

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