

**Synrchi Wellness & Relaxation Centre  
Confidential Client Intake Form**

Name: \_\_\_\_\_ Sex:    Male    Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ if less than 5 years previous job \_\_\_\_\_

Who referred you to this office? Name: \_\_\_\_\_

Phone book    Advertisement    Sign    Other \_\_\_\_\_

Marital Status:    Married    Single    Divorced    Widowed

Children:    Yes    No    How Many? \_\_\_\_\_

Name of Spouse/Significant Other: \_\_\_\_\_

In case of Emergency, Please notify: \_\_\_\_\_

Phone number: \_\_\_\_\_ Cell number: \_\_\_\_\_

Notice to Clients

Healing is the art and science of assisting the restoration of health at all levels of a person's being, irrespective of where ill health has manifested. In accordance with our profession, we have to advise you that the advice given to you by a Healer may differ from the theories and practices of the Medical Profession.

The Healer may not diagnose, prescribe for, nor treat, any specific illness. If you have a definite medical problem, you are advised to seek professional medical help.

As a Healer, we subscribe to a Code of Conduct and abide by a stringent Code of Ethics. The aim is to provide clients with the highest standard of healing, which is always "in addition to" and NEVER "instead of" professional medical care.

List other bodywork therapies you have received (reiki, chiropractic, acupuncture, etc.)

\_\_\_\_\_

Describe the exercise activities you do and how often: \_\_\_\_\_

Why are you here today? \_\_\_\_\_

Are you sensitive or ticklish to touch/pressure in any areas? \_\_\_\_\_

List any medications (including aspirin, etc.) and nutritional supplements you are taking or have taken in the last 1 year \_\_\_\_\_

Check the following conditions that apply to you, past (within 5 years) and present. Please add your comments.

**Musculo-Skeletal**

Headaches Frequency: \_\_\_\_\_

Joint Stiffness/swelling

Spasms/cramps

Strains/sprains

back, hip pain

Shoulder, neck, arm pain

Leg, foot pain

problems walking

jaw pain/ TMJ

Tendonitis

Bursitis

Arthritis

Osteoporosis

Scoliosis

Bone or joint disease

**Circulatory & Respiratory**

Dizziness

Shortness of breath

Fainting

Cold hands and feet

Cold sweats

Swollen ankles

Varicose veins

Blood clots

Stroke

High Cholesterol

Heart condition

Sinus problems

Asthma

High blood pressure

Low blood pressure

Lymphedema

**Skin**

Rashes

Skin Allergies

Athlete's Foot

**Digestive**

Nervous stomach

Indigestion

Constipation

Intestinal gas/bloating

Diarrhea

Diverticulitis Onset: \_\_\_\_\_

Crohn's Disease

Colitis

**Nervous system**

Numbness/tingling

Face twitches

Fatigue

Chronic pain

sleep disorders

Herpes/Shingles

Cerebral Palsy

Epilepsy

Chronic Fatigue Syndrome

Multiple Sclerosis

**Other**

Drug use: \_\_\_\_\_

Alcohol use: \_\_\_\_\_

Caffeine use: \_\_\_\_\_

Nicotine use: \_\_\_\_\_

diabetes

Fibromyalgia

cancer

hyper/hypothyroidism

hepatitis

HIV/AIDS

other: \_\_\_\_\_



Please list any additional comments regarding your health: \_\_\_\_\_

\_\_\_\_\_

I understand that the information I have provided will be held in the strictest confidence and that I have the right to view my records upon written request.

I further understand that the therapy I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension/pain. Additionally, I understand that this therapy 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.

Because this therapy is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered honestly, I agree to keep the practitioner updated as to any changed in my medical profile, and understand that there shall be no liability on the practitioner's part should I forget to do so.

Should I need to cancel future sessions, I agree to give my practitioner 24 hours' notice or I will be financially responsible for the session time.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_