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Welcome!

Intake Form

Please complete the following information.

Name:_____ Telephone: _____

Address:_____

E-Mail:_____ Date of Birth:_____

Would you like your email to be added to my newsletter for updates and educational/inspirational messages? **Y/N**

Occupation:_____ Referral source:_____

Emergency Contact and Phone: _____

If needed, may we share your information with your physician for coordination of care? **Y/N**

Please provide your Physician/Clinic Address and Phone Number: _____

_____

What brings you here? _____

_____

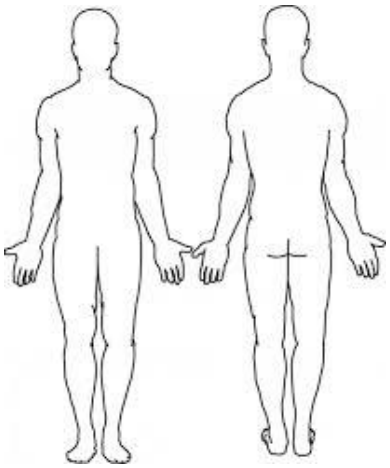
What specific body areas or emotional/mental concerns would you like addressed?

_____

Are there any areas you are not comfortable with receiving body work or energy work on?

_____

Please mark any areas that may be causing physical discomfort.



When did the discomfort first start, including what was going on in your life during that time? _____

_____

What relieves the discomfort? What makes it worse?

_____

Precautions/Contraindications: _____

Regular Exercise? **Y/N**
Type of exercise/how often:_____

Do you suffer from stress frequently? **Y/N**
How do you cope/relax/de-stress?_____

What gives you meaning/purpose in life? _____

Have you had a recent stroke, seizure, or head and/or neck injury? If so, please explain:

_____

_____

Please indicate if any of the following apply to you:

- □ Diabetes
- □ Frequent Headaches
- □ Back Pain
- □ Arthritis
- □ Osteoporosis
- □ Herniated Disc _____
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Epilepsy or Seizures. Please explain _____
- □ Fatigue/Tired
- □ Any Allergies _____
- □ Pregnancy
- □ Anxiety
- □ Depression
- □ ADHD/ADD
- □ Addiction/Recovery, Smoking or Eating Disorder
- □ Injuries_____
- □ Numbness_____
- □ Stroke_____
- □ Surgery _____
- _____
- □ Any other Mental/Physical condition_____

Please list any Medications/Herbs/Vitamins/Supplements and why you are taking them:

_____

_____

Please indicate the services you are interested in experiencing or learning more about:

- □ Meditation & Relaxation
- □ Guided Imagery
- □ Spiritual Coaching
- □ Reiki/Energy Healing
- □ Deep Tissue/ Neuromuscular Therapy
- □ Cranial Sacral Therapy
- □ Therapeutic Yoga
- □ Coping Skills/ Stress Management
- □ Pain Management

What goals would you most like to achieve?

_____

_____

How will you know you have reached these goals?

_____

_____

Are your health-related goals part of a legal case? Y/N

COVID-19 Addendum

Have you been tested for COVID-19? If yes, what type of test did you have? _____
When was your test? _____ What were the results? _____
Have you been in places with a high infection rate within the last two weeks? (e.g., state designated "hotspots")? If yes, please explain. _____
Please check if you are experiencing any of the following as a new pattern since the beginning of the pandemic:

_____ Fever ____Nasal, sinus congestion _____ Sudden onset muscles soreness
_____Chills ____Loss of smell, taste _____Rash, skin lesions (especially on feet)
_____Sore throat. ____Digestive upset, diarrhea _____Fatigue
_____Shortness of breath

Payment and Cancellation Policy
All services are rendered on a fee for service basis. I am sorry that I do not take health insurance or Medicare. You are expected to pay for services at time of treatment. Full payment is due if you cancel a scheduled session with less than 24 hours' notice.

Client Signature_____Date_____

Client Confidentiality/HIPPA Policy

As a practitioner, I am dedicated to providing you with the best of care and protecting your privacy.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to conduct, plan, and direct treatment and follow-up among healthcare providers who may be involved in that treatment directly or indirectly as needed.

I am aware that all information exchanged through verbal, written, email, and voicemail shall be confidential and the relationship between client and practitioner shall be respected. Confidentially between practitioner and client shall be maintained unless unlawful issues or intent to harm another or oneself dictate otherwise. This office will not use or disclose information about you for the purposes of marketing and will not sell your information to unrelated companies.
Patient Rights:

- Protected Health Information is used for the purposes of treatment, payment, and healthcare operation.
- The office has a copy of the Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- Upon written request you have the right to access, review or receive copies of your healthcare records.
- You have the right to provide a written request of how your private information is used or disclosed to carry out treatment, payment, or healthcare operations.

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Practices for healthcare services.

Client Signature_____Date_____

Client Waiver

I understand that the Mind, Body & Spirit services I receive from Deborah A. Rogers, OTR/L are provided for the purpose of relaxation and relief of muscular tension. This may support me to maintain my health, recover from illness or be better able to cope with current life situations, so I can lead a more healthy and joyful life. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the service can be adjusted to my level of comfort. I further understand that these Mind, Body & Spirit services should not be construed as a substitute for medical examination or psychological diagnosis or treatment, and that I should see a physician, psychologist, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that Mind, Body & Spirit practitioners are not qualified to 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 Mind, Body & Spirit services 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that the practitioner will be placing hands on or above me during an energy healing and/or body work session. I also understand that any illicit or sexually suggestive remarks

or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature_____Date_____

Client Waiver COVID-19 Addendum

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner.

I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Client Signature_____Date_____

Do No Harm Policy
I agree to fully release and hold harmless Deborah A. Rogers-Culotti, OTR/L from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with:

Client Signature_____Date_____

Consent to Treatment of Minor: By my signature below, I hereby authorize Deborah A. Rogers, OTR/L to administer Mind, Body & Spirit services to my child or dependent (name)_____ as deemed necessary.

Signature of Parent or Guardian_____ Date_____

Thank you for taking the time to complete these forms.