**HEALING HANDS NATURAL THERAPY SPA** CLIENT INTAKE FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive Healing Hands news and special offers? Yes or No Okay to text reminders? Yes or No

**\*\*Healing Hands Spa will NOT share any personal information such as address, phone numbers, or emails.\*\***

**CUPPING**

**PLEASE READ THOUROUGHLY AND INITIAL NEXT TO EACH STATEMENT BELOW:**

\_\_\_\_\_\_\_\_ I understand that all treatments at Healing Hands Natural Therapy Spa are therapeutic in nature and I agree to communicate to the therapist any physical discomfort or draping issues during the session.

\_\_\_\_\_\_\_\_ Information has been provided to me about Cupping Therapy. I understand the potential effects, side effects and after care recommendations.

\_\_\_\_\_\_\_\_ I do not have any listed contraindications and I have fully disclosed all health factors to my therapist, including any that may not be listed on the intake form.

\_\_\_\_\_\_\_\_ I understand that there could be discolorations on my skin that may occur from receiving Cupping Therapy.

\_\_\_\_\_\_\_\_ I understand discolorations could possibly be visible for up to two weeks or even longer. These discolorations are not bruises or injuries.

\_\_\_\_\_\_\_\_ I understand that after receiving Cupping Therapy I could possibly feel “achy”, have a headache, etc. that will subside with rest and rehydration.

\_\_\_\_\_\_\_\_ I understand that after Cupping Therapy, activities such as aggressive exfoliation or shaving (for 4 hrs after treatment) is not recommended.

\_\_\_\_\_\_\_\_ I understand that Cupping cannot be performed if I have a sunburn.

\_\_\_\_\_\_\_\_ It is recommended that I should avoid exposure to cold, wet/windy weather, hot showers/baths, saunas/hot tubs, and aggressive exercise for 4-6 hours after Cupping Therapy.

**CONTRAINDICATIONS OF CUPPING THERAPY:**

\*History of blood clots \*Current Chemo Treatment

\*Taking blood thinners \*Recent Surgery (Including Dental)

\*Severe Neuropathy \*Computer/Electronic Implants

\*Pregnancy \*Current Pain Medication

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow the cupping practitioner of Healing Hands Natural Therapy Spa in Kokomo Indiana to perform Cupping Therapy. I also agree that I do NOT have any of the above listed contraindications. I also agree that I have read, understand, and will follow all the information stated on this form. I also agree that I will not hold the practitioner or Healing Hands Natural Therapy Spa responsible for any injury resulting directly or indirectly from Cupping Therapy.

**Client Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to Treatment of Minor Under the Age of 17: By my signature below, I hereby authorize a Licensed or Registered Therapist to administer massage, facial, manicures and pedicures to my child or dependent as they deem necessary.

**Signature of Parent or Guardian**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_