***Ka Malama `Anela 702-900-7189***

**Kilani Pedro, L.M.T.** *LIC# NVMT 8362*   *www.HuiOAnela.com*

Certified Angel Intuitive, Kahuna, CACR, CATR Kahuna@HuiOAnela.com

# Client Intake Form:

Name Cell # Home #

Address

Email Address Date of Birth

Years / Months

Relation

Occupation

Emergency Contact

Phone #

**The following information will be used to design safe and effective massage sessions. Please answer the questions to the best of your knowledge. Your answers will be discussed at the start of each session.**

Date of Initial Visit Referred By

* Have you had a professional massage before? Yes No If

If yes, how often do you receive massage therapy?

* Do you have any difficulty lying on your front, back, or side? Yes No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

* Do you have any allergies to oils, lotions, ointments, holistic herbs or scents? If yes, please explain
* Do you have sensitive skin? Yes No
* Are you wearing contact lenses ( ) dentures ( ) hearing aid(s) ( )?

|  |  |  |
| --- | --- | --- |
| * Do you sit for long hours at a workstation, computer, or driving? Yes If yes, please describe | No  No |  |
| * Do you perform repetitive movements with work, sports, or hobbies? If yes, please describe | Yes |  |
| * Do you experience stress in your work, family, or other aspect of your life? | Yes | No |

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

What type of massage are you seeking *(select all that apply)*? Relaxing Angel Intuitive CranioSacral Sports

Trigger Point Clinical Bodywork (Myofascial Repatterning) Reflexology Reiki / Energy I’m undecided

**What pressure do you prefer?** **Deep / Trigger Point** **Medium** **Light**  **Energy work**

Any areas of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please identify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any particular goals in mind for this angel intuitive massage session? Yes No

If yes, please share \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any areas *(face, abdomen, feet, etc.)* you do not want massaged? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Muscle Tension ( ) Anxiety ) Insomnia ( ) Irritability Other

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# Medical History:

* Are you currently seeing a medical practitioner or chiropractor? Yes No
  + If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are you currently taking any medication? Yes No
  + If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Please circle all that applies to you :**

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Anxiety / Depression / Stress / PTSD

\*Recent / current fever

Swollen glands

Fatigue / Anemia

Bruise easily / Hemophilia

Open sores / wounds

\*Recent fracture / strain / sprain

Neck / back pain or injury

Leg / knee pain or injury

Jaw clenching / Teeth grinding

Joint disorder / Tendonitis

Surgeries *(in the last 18 months)*

Allergies / Skin or other sensitivities

Breathing problems / Asthma

Arteriosclerosis / Atherosclerosis

Varicose Veins / Phlebitis

Deep Vein Thrombosis / Blood clots

Headaches / Migraines

Epilepsy / Seizures

Diabetes / Neuropathy

Fibromyalgia / Multiple Sclerosis

Cancer

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Recent = within the last two weeks* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contagious skin condition

Heart condition

High or low blood pressure

Decreased sensation

Carpal Tunnel Syndrome

Tennis Elbow / Golfer’s Elbow

Scoliosis / Lordosis / Kyphosis

Sciatica / Pseudo-Sciatica

TMJS / TMD (Jaw pain)

Rheumatoid Arthritis / Osteoarthritis

Artificial Joint / Pins / Plates / Pacemaker

Pregnant ~ wks. / mos.? \_\_\_\_\_\_\_\_\_\_\_\_

Please explain the circled conditions above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you drink alcohol or take recreational drugs? Yes No ~ If yes, has it been more than 48 hours? Yes No

*Kilani Pedro DBA Ka Malama `Anela and Hui O `Anela* invites you to ask any questions regarding all available products and services*. The most effective therapeutic massage will comprise of the mutual understanding, trust, and compassion shared between a massage therapist and client.*

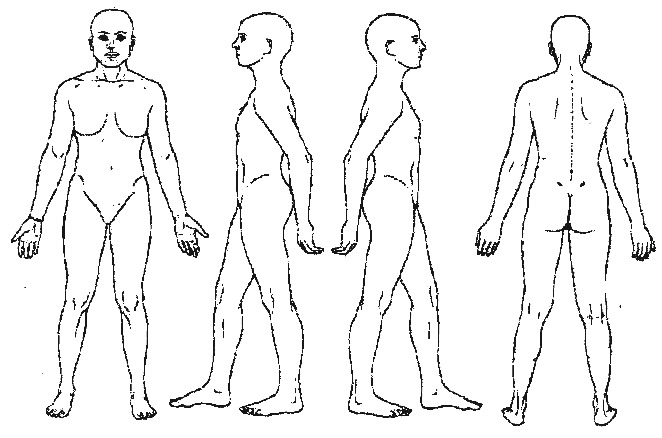
Full payment is required for all services rendered prior to session. All services and products may be securely purchased prior to any session online by visiting [*www.HuiOAnela.com*](http://www.HuiOAnela.com)*.* If web access is not available, cash, debit, or credit card may be accepted beforehand. Tips are appreciated.

\*\***NO REFUNDS ON ALL SERVICES. NO EXCEPTIONS**. \*\*

**Please be available (20) twenty minutes before your session for paperwork, payment, and table set-up/session preparations. .**

**Please mark areas of discomfort with an *X* and**

***CIRCLE* areas you would like to focus on.**



**I authorize *Ka Malama `Anela* to release all information requested, in writing, by/to my medical provider, clinic, or hospital. Otherwise, I understand that my private health information is protected under HIPAA**: [www.hhs.gov/hipaa/](https://www.hhs.gov/hipaa/)

I agree to keep my massage therapist informed of changes to my medical profile and will update my file of these changes. Since massage should not be performed with certain medical conditions, medications or while under the influence, I affirm that I have answered all questions to the best of my knowledge and stated all known medical conditions. I also accept my responsibility in communicating my comfort level throughout the session. I understand that there shall be no liability on the massage therapist’s part should I fail to do any of the above. I have read, understand, and agree to all the terms and policies provided to me.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Client’s Signature of Acknowledgement Print Name Date*

If yes, please explain

Cir

cle any specific ar

eas you would like the

Massage therapist to concentrate on

During the session:

Continued on page 2

