

Client Intake Form

Personal Information

Name _____ Phone (M / H / W) _____

Email _____ Date of Birth _____

Address _____ City/State/Zip _____

Occupation _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about me? _____

Medical Information

Are you taking any medications? yes no

If yes, please list name and use: _____

Please indicate any of the following that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Allergies/Sensitivities | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Sprains or Strains |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Other |
| <input type="checkbox"/> Orthopedic Injuries | |

Explain any condition you have marked above:

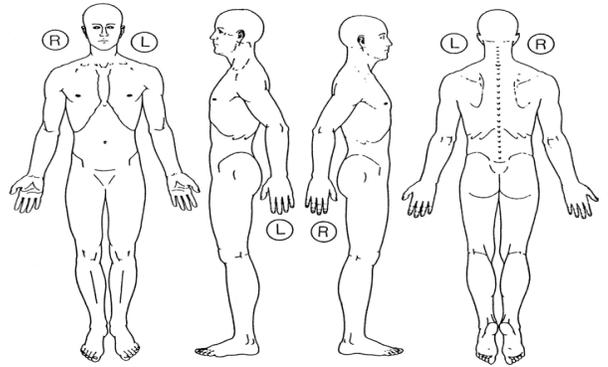
Please list any treatments you are currently undergoing for health conditions, including alternative modalities like acupuncture, chiropractic, massage, etc

Please list any major life traumas (injuries, hospitalizations, loss of a loved one, etc) and approximate age:

Session Information

What are your goals for treatment, and major challenges you'd like to overcome? _____

Please circle any areas of physical discomfort



What factors do you think may be contributing to your health challenges? (Injury, diet, lifestyle, family history, job, stress, relationships, illness, finances, drug or alcohol use, etc)

By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Signature _____ Date _____

Informed Consent and Liability Waiver

I understand that all massage/bodywork/energy healing techniques utilized by Kristian Googe and Vitality Wellness by Kris, LLC (“Vitality Wellness”) are provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow. These techniques support the body’s natural ability to heal by promoting harmony and balance within. Detailed descriptions of all services offered are available at www.yourpathtovitality.com

Any Distance Healing sessions I may participate in are completed via Zoom or via Email, and a copy of all session notes will be sent to me afterward. In either case, I understand the therapist will make a temporary connection to me through a higher energetic source to identify any imbalances which need to be cleared. Any and all connections made are intended for my highest truth and good, and great care is taken in this process. The therapist may act as proxy on my behalf or may send energy healing through a proxy doll. The temporary connection will be automatically closed at the end of the session. I am encouraged to ask questions about this process or anything else that comes up during my sessions.

If I experience pain or discomfort during the session, I will immediately inform my therapist so the session can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session. All modalities/techniques, including medical massage, can be performed over the clothes. In the rare event draping is necessary, only the area being worked on will be uncovered.

I understand that my therapist is not a doctor, and any services offered during sessions are not a substitute for medical care. My therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness. No claims are made as to healing or recovery from any illness I may have now, nor the prevention of any illness I may have in the future. No guarantee is made towards validity. Any suggestions made regarding supplementation or home programs of any kind should not be considered as prescriptions. I may follow these suggestions at my own risk, with the recommendation that I seek the advice of my primary doctor to ensure there are no contraindications.

I understand that my client information and records are treated in a confidential manner, compliant with HIPAA. I have the right to discontinue services, change consent, or leave at any time.

While most energy healing methods are gentle, there may be risks. In approximately 20% of sessions, “processing” may occur as the energy body adjusts. Temporary symptoms may include irritability, fatigue, headaches, or sleep disturbances. This “processing” appears to be a normal part of regaining energetic balance and typically lasts no more than 48 hours. Staying hydrated may ease these symptoms if they occur.

I understand that all necessary precautions are being taken, including sanitation and disinfecting practices recommended by the CDC and WHO, to ensure everyone’s health and safety, and to limit the spread of communicable diseases such as Flu, Covid-19, etc. I agree to reschedule my in-office appointment, or switch it to a distance healing session, if any of the following statements apply in the 15 days leading up to any appointment I schedule: I am exhibiting symptoms or have exhibited symptoms; I have knowingly been exposed; or I have received a positive diagnosis which has not been followed by a negative test result. I agree to inform my therapist of any exposure risks I become aware of following my appointment so necessary steps can be taken to reduce the possible spread to other clients. I understand my therapist will inform me of any exposure risks that may arise so I can make the best decisions for myself and my health.

Except in the case of gross negligence or malpractice, I and my representatives (spouse, heirs, executors, administrators, legal representative, etc) agree to fully release and hold harmless Kristian Googe and Vitality Wellness for and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my sessions, including but not limited to the unintentional exposure to or harm from COVID-19 or other infectious diseases.

X _____

Client Name (Print)

X _____ **X** _____

Client Signature

Date