NEUROSOMATIC
THERAPY OF NJ
RETRAIN YOUR NERVOUS SYSTEM. RECLAIM YOUR LIFE.

New Patient Intake Form

Personal Information

Full Name: _____

Phone Number: _____

Date of Birth: _____

Email: _____

Address: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Goals for Treatment

Please describe your goals for today's session and any areas of concern:

_____

_____

_____

NEUROSOMATIC
THERAPY OF NJ
RETRAIN YOUR NERVOUS SYSTEM. RECLAIM YOUR LIFE.

Health History

Do you have any current injuries or medical conditions?

☐ Yes ☐ No

If yes, please explain:

_____

_____

Please check conditions that apply to you:

☐ Blood Clots / Deep Vein Thrombosis (DVT)
☐ Headaches / Migraines
☐ Cancer (Current or Past)
☐ Muscle or Joint Pain
☐ Osteoporosis
☐ Arthritis
☐ Numbness / Tingling
☐ Neck or Back Pain
☐ Autoimmune Disorder
☐ High Blood Pressure
☐ Neurological Condition
☐ Heart Condition
☐ Unexplained Swelling or Severe Pain
☐ Diabetes
☐ Recent Surgery (within the past 6 months)
☐ Recent Injury
☐ Pregnancy
☐ Other: _____

Are you currently under medical care?

☐ Yes ☐ No

Practitioner Name: _____

Current Pain Level

Please circle your current pain level:

1 2 3 4 5 6 7 8 9 10 (1 = Minimal Pain, 10 = Severe Pain)

NEUROSOMATIC
THERAPY OF NJ
RETRAIN YOUR NERVOUS SYSTEM. RECLAIM YOUR LIFE.

Consent and Acknowledgment

I understand that the services provided are within the scope of massage therapy and/or bodywork and that the practitioner is not a medical doctor. All services are performed in accordance with the laws and regulations governing massage therapy in the State of New Jersey.

I understand that massage therapy and bodywork are not intended to diagnose, treat, cure, or prevent any disease or medical condition and are not a substitute for medical care or medical treatment. I acknowledge that it is my responsibility to consult a licensed physician or qualified healthcare provider regarding any medical concerns.

I affirm that I have disclosed all known medical conditions and will inform the practitioner of any changes in my health status.

I understand that while massage therapy is generally safe, there are potential risks including, but not limited to:

- Temporary soreness or discomfort
- Bruising or mild inflammation
- Dizziness or fatigue

I understand that certain medical conditions may require written physician approval prior to treatment. The practitioner reserves the right to refuse or postpone treatment when massage/bodywork may not be appropriate or safe.

I understand that treatment may involve therapeutic touch to areas including but not limited to the neck, shoulders, hips, glutes, abdomen, or chest-adjacent musculature as clinically appropriate.

I understand that I may ask questions, request adjustments in pressure, decline any technique, or stop the session at any time.

I understand that all client information and health history will be kept confidential and used solely for treatment purposes unless disclosure is required by law.

By signing below, I voluntarily consent to receive massage therapy and/or bodywork services. **Client Initials**: _____

Appointment & Cancellation Policy

Please provide at least 24 hours' notice for cancellations or rescheduling. Missed appointments or cancellations made with less than 24 hours' notice may be subject to a cancellation fee.

Clients arriving late may receive a shortened session in order to avoid delaying subsequent appointments. Full session fees will still apply. **Client Initials**: _____

Patient Full Name: _____Date: _____

Practitioner's Signature: _____Date: _____