New Client Intake Form & Information Sheet

Welcome to Apothecary Tinctura!

We are a retail medicinal herb store specializing in natural remedies and health solutions for women. We have a small but busy 'clinic'/healing center/spa where we offer private consultation and treatments by skilled practitioners in a safe, nurturing environment. We specialize in women's health care integrating herbal medicine, aromatherapy, dietary counseling and Maya Uterine Massage into comprehensive holistic treatment plans.

Our mission is to provide an environment that allows healing to naturally happen…where all aspects of who we are and what our lives are about are welcome. Our goal is to provide you with the information and educational avenues needed to support self-healing and integration of herbal medicines, natural remedies and elements of self-care and beauty into your life. Whether you are here for a nurturing massage or have come seeking support for more serious health challenges, we welcome you.

How to Find Us

We are located on the corner of 6th Avenue & Fillmore St. just north of Cherry Creek
address: 2900 East 6th Ave, Denver 80206 tel: 303.399.1175

Cancellation / Re-Scheduling Policy

In order to best serve our clients and respect our clinic practitioners:

- We ask for a credit card number to reserve all clinic appointments
- We require at least 24 hours notice to cancel or reschedule an appointment
- We will not charge your credit card unless you miss your appointment or cancel/change your appointment with less than 24 hours notice
- A $45 cancellation/rescheduling fee will be charged if less than 24 hours notice is given

I have read and understand the cancellation/re-scheduling policy

Client signature___________________________________ date ________________

scheduled date and time of first visit ___________________________________

We look forward to seeing you soon! Please bring your completed intake form with you to your first appointment.

Apothecary Tinctura
Massage Intake Form

Date:_________

Name: ______________________________________ Age:______
Address:____
City_________________________ State______ Zip Code______________
Phone: (day)________________________ (evening)___________________________
E-mail:____
How did you find us? Referred by:____

What would you like help with at this time?
____
____
____

Present physical complaints:
____
____
____

List any medications, herbal medicines, supplements, or over the counter medications you are presently taking:
____
____
____

Occupation____
Do you enjoy your job?____

Circle posture assumed most of the day: Standing/Stationary Standing/Moving
Sitting/Computer Sitting/Driving
Other______________________________
Have you had a professional massage before? Yes or No
Anything you really liked or disliked about your previous massages?
____

Exercise (type & how often?)____
Rate your general energy level (1-10) ______________Rate your stress level (1-10)_____________
What are your major stressors (circle): Job Family Finances School Relationships
Health Other ____
____

Where in your body do you hold your tension? _______________________________________

Surgical history (please include date):
____
____
____

Any serious accidents, falls or injuries, childhood accidents or physical traumas:
____
____

Are you currently under medical supervision? Yes or No
If yes, for what condition? ____

Do you have or have you had any of the following chronic conditions?.

_____ Allergies (oils, lotions, herbs)
_____ Headaches
_____ Asthma
_____ Diabetes
_____ High blood pressure
_____ Low blood pressure
_____ Spider/Varicose veins
_____ Cancer
_____ Heart disease
_____ PMS
_____ Digestive problems
_____ Depression
_____ Anxiety
_____ Other
_____ Skin fungus
_____ HIV+
_____ Osteoporosis
_____ Insomnia
_____ Spinal problems
_____ Arthritis

Other health issues you'd like me to be aware of:
____
____
____
____

Please list the areas that cause you the most pain or where you feel you hold tension:
____
____
____
____