APOTHECARY TINCTURA

New Client Intake Form & Information Sheet

Welcome to Apothecary Tinctura!
We are a retail medicinal herb store specializing in natural remedies and health solutions. 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.

Our mission is to provide an environment that allows healing to naturally happen…where all aspects of who you are and what your life is about is 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 48 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 cancellation/rescheduling fee equal to the session booked will be charged with less than 24 hours notice.

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

Client signature_____ date _____

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

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Massage Intake Form

Date:_____

Name: _____ DOB:_____

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): _____

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

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

_____

_____

_____

PRENATAL MASSAGE:

Expected due date_____ # of weeks pregnant_____

Name of your Doctor or Midwife_____ Phone_____

Are you seeing a doctor/midwife regularly? YES or NO Date of last visit_____

How has your pregnancy been progressing? (physically/emotionally)_____

Have you had any problems/complications or been at high risk in this pregnancy? Y or N

If yes, please explain:_____

Is this your first pregnancy? yes/no

Have you had a prenatal massage before? Y or N Date of last prenatal massage_____

Anything you really liked/disliked about it? _____