Shabbazz Organics LLC
525 N. Sam Houston Pkwy E. Suite 521, Houston, TX 77060
832-267-4495 | shabbazzorganics@gmail.com | shabbazzorganics.com

Client Intake & Consent Form

CLIENT INFORMATION

Full Name: _____ **Date of Birth:** _____

Age: _____ **Phone:** _____ **Email:** _____

Address:

_____

Emergency Contact: _____ **Emergency Contact Phone:** _____

☐ Preferred Contact: Phone ☐ Preferred Contact: Text ☐ Preferred Contact: Email

VISIT TYPE / REFERRAL SOURCE

☐ First Visit ☐ Follow-Up Visit ☐ Attorney Referral

☐ Doctor / Clinic Referral ☐ Walk-In ☐ Wellness Client

☐ Post-Accident Recovery ☐ Other

Referred by / Office / Attorney / Provider:

_____

SERVICE REQUESTED

☐ Massage Therapy ☐ Red Light Table Session ☐ Massage Chair Session

☐ Inversion Therapy ☐ Wellness Recovery Session ☐ Combination Session

☐ Other

MAIN REASON FOR VISIT

Please describe what brings you in today:

_____

Date symptoms started: _____ **Accident / Injury Date, if applicable:** _____

☐ Related to accident or injury: Yes ☐ Related to accident or injury: No ☐ Auto accident

☐ Slip and fall ☐ Work injury ☐ Sports injury

☐ Lifting injury ☐ Unknown ☐ Other

PAIN / DISCOMFORT ASSESSMENT

Current discomfort level: 0 = no discomfort, 10 = severe discomfort.

Before Session Pain Level 0-10: _____ **After Session Pain Level 0-10:** _____

Primary Area of Discomfort: _____ **Secondary Area of Discomfort:** _____

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- [ ] Sharp
- [ ] Dull
- [ ] Aching
- [ ] Burning
- [ ] Tight
- [ ] Stiff
- [ ] Tingling
- [ ] Numb
- [ ] Spasm
- [ ] Heavy
- [ ] Radiating
- [ ] Other

What makes it worse?

What makes it better?

BODY AREA CHECKLIST

- [ ] Head / scalp
- [ ] Jaw
- [ ] Neck
- [ ] Shoulders
- [ ] Upper back
- [ ] Mid back
- [ ] Lower back
- [ ] Hips
- [ ] Glutes / sciatic area
- [ ] Chest / ribs
- [ ] Abdomen
- [ ] Arms
- [ ] Elbows
- [ ] Wrists / hands
- [ ] Thighs
- [ ] Knees
- [ ] Calves
- [ ] Ankles / feet
- [ ] Full body tension

HEALTH HISTORY

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Heart condition
- [ ] Diabetes
- [ ] Neuropathy
- [ ] Blood clot history
- [ ] Stroke history
- [ ] Cancer history
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Autoimmune condition
- [ ] Rheumatoid arthritis
- [ ] Osteoporosis
- [ ] Herniated disc
- [ ] Sciatica
- [ ] Recent surgery
- [ ] Recent fracture
- [ ] Skin infection / rash
- [ ] Open wound
- [ ] Varicose veins
- [ ] Pregnancy
- [ ] Pacemaker / implantable device
- [ ] Metal implants
- [ ] Seizure history
- [ ] Light sensitivity
- [ ] Taking blood thinners
- [ ] Taking pain medication
- [ ] Other

Current medications, supplements, pain relievers, muscle relaxers, blood thinners, or topical treatments:

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CONTRAINDICATION SCREENING

Please answer each screening item before services are performed.

- ☐ Fever/contagious illness/infection: Yes
- ☐ Swelling/redness/heat/severe pain: Yes
- ☐ Known or suspected blood clot: Yes
- ☐ Surgery in the last 6 weeks: Yes
- ☐ Open wounds, burns, or active skin lesions: Yes
- ☐ Pregnant or possibly pregnant: Yes
- ☐ Implanted medical device: Yes
- ☐ Sensitive to light or heat: Yes
- ☐ Doctor advised avoid services: Yes

- ☐ Fever/contagious illness/infection: No
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- ☐ Known or suspected blood clot: No
- ☐ Surgery in the last 6 weeks: No
- ☐ Open wounds, burns, or active skin lesions: No
- ☐ Pregnant or possibly pregnant: No
- ☐ Implanted medical device: No
- ☐ Sensitive to light or heat: No
- ☐ Doctor advised avoid services: No

Explain any Yes answers:

CLIENT CONSENT

I understand that services provided by Shabbazz Organics may include massage therapy, red light table sessions, massage chair sessions, inversion therapy screening, and general wellness recovery services. Massage therapy is performed only by a licensed massage therapist where required. Red light table sessions, massage chair sessions, and other wellness services are not emergency medical services and are not substitutes for medical diagnosis or treatment. I agree to communicate any discomfort, pain, dizziness, numbness, shortness of breath, skin irritation, anxiety, or unusual symptoms before, during, or after my session. I understand that I may stop or modify the session at any time. I understand that results vary and no specific outcome is guaranteed.

Client Initials:

RELEASE OF INFORMATION

I authorize Shabbazz Organics to release attendance records, invoices, session notes, and progress summaries to the authorized party listed below.

- ☐ Referring doctor / clinic
- ☐ Insurance-related representative
- ☐ Referring attorney
- ☐ Other authorized party

Authorized Party Name: **Phone / Fax / Email:**

Client Initials:

PAYMENT RESPONSIBILITY

I understand that I am responsible for payment unless other written arrangements have been approved by Shabbazz Organics.

- ☐ Cash
- ☐ Credit / Debit Card
- ☐ Package
- ☐ Invoice
- ☐ Letter of Protection, if approved
- ☐ Other

Client Initials:

CLIENT SIGNATURE

Client Signature: _____

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Printed Name: _____ **Date:** _____

Staff Witness: _____

COMPLIANCE STATEMENT

We do not diagnose, prescribe, replace medical care, or guarantee legal/medical outcomes. Services are wellness-based and adjunctive to appropriate medical care.