Nikaelae Wellness – Intake & Consent

At Nikaelae Wellness, your wellbeing, comfort, and autonomy are deeply respected. This Client Intake & Consent Form is designed to help us understand your needs, support your safety, and deliver care that is informed, ethical, and aligned with your goals. All information provided is treated confidentially and held with care.

We collect basic client and health history information to ensure safe, supportive care. Please disclose any current conditions, medications, or goals you wish to work with.

By attending your session, you agree to participate voluntarily and understand our services are complementary and not a substitute for medical care. Communication is encouraged before, during, and after each session.

Section 1: Client Information

Full Name: _____

Date of Birth: _____

Gender: ☐ Female ☐ Male ☐ Other _____

Email: _____

Phone: _____

Occupation: _____

Address: _____

City: _____ Postcode: _____

Unit (if applicable): _____

Parent/Guardian Name (if applicable): _____

Relationship to Client: _____

Emergency Contact Name: _____

Relationship to Client: _____

Emergency Contact Phone: _____

Referred By (if applicable): _____

Policies at Nikaelae Wellness are reviewed periodically to ensure alignment with best practices, service updates, and the evolving needs of our clients.

This policy was last reviewed on: **Saturday, 19 July 2025**

Section 2: Practitioner & Health Disclosures

Have you had any complementary therapies before? ☐ Yes ☐ No
If yes, please list:

Are you currently under the care of a physician or specialist? ☐ Yes ☐ No
If yes, please specify:

Practitioner Name: _____

Contact Details (if available): _____

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Do you have any known allergies or sensitivities? ☐ Yes ☐ No

Please specify: _____

Are you currently taking any medications or supplements? ☐ Yes ☐ No

Please list with purpose if possible: _____

Do you have any recent injuries or past surgeries? ☐ Yes ☐ No

Please specify: _____

Section 3: Health & Body Systems Review

Please tick any relevant symptoms, conditions, or issues:

Mental & Emotional

☐ Headaches/Migraines
☐ Anxiety
☐ Depression
☐ Fatigue
☐ Stress/Overwhelm
☐ Mood Swings
☐ Poor Memory
☐ Other: _____

Nervous System

☐ Dizziness
☐ Tingling/Numbness
☐ Restless Legs
☐ Shooting Pains
☐ Tremors
☐ Unsteady Gait
☐ Other: _____

Circulatory System

☐ High/Low Blood Pressure
☐ Varicose Veins
☐ Swelling
☐ Bruising
☐ Blood Clots
☐ Heart Conditions
☐ Stroke
☐ Other: _____

Respiratory System

☐ Shortness of Breath
☐ Asthma
☐ Cough
☐ Other: _____

Musculoskeletal System

☐ Pain/Stiffness
☐ Injuries
☐ Arthritis
☐ Fibromyalgia
☐ Disc/Sciatica
☐ Other: _____

Sleep & Skin

☐ Difficulty Sleeping
☐ Night Sweats
☐ Itchiness/Rashes
☐ Eczema
☐ Other: _____

Serious Illnesses or Surgeries

☐ Cancer
☐ Tumor
☐ Autoimmune
☐ Surgery
☐ Infectious Disease
☐ Other: _____

Anything else you'd like to share?

Section 4: Treatment Goals

What areas of your life would you like to work with?

(Physical, emotional, energetic, spiritual, behavioral, etc.)

What are your expectations or desired outcomes from treatment?

(e.g. reduce stress, manage pain, feel more grounded, improve sleep)

Section 5: Client Consent & Waiver

Please read and mark the following:

☐ I confirm that all the above information is correct to the best of my knowledge.

☐ I understand that any information I provide is confidential and used only for the purpose of supporting my treatment. It may be shared with other health professionals only with my consent, when required by law, or with emergency services in the event of an emergency.

☐ Do you consent for First-Aid to be provided in the case of an emergency?

☐ Yes | ☐ No

☐ I understand that the services provided are complementary in nature and are not a substitute for medical advice or treatment.

☐ I acknowledge that my therapist is not a medical doctor and will not provide medical diagnoses.

☐ I will communicate openly if I experience any discomfort during the session.

☐ I agree to inform my therapist of any relevant changes to my health status.

☐ I understand that treatment is strictly non-sexual in nature and any inappropriate conduct will end the session.

☐ I consent to receive services and understand that I do so at my own risk. I waive and release the therapist from liability related to treatment outcomes, present or future.

Section 6: Signatures

Client Name: _____

Client Signature: _____ Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____ Date: _____

Therapist Name: _____

Therapist Signature: _____ Date: _____