



Client Intake Form

Client Contact Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Cell: _____

E-mail: _____

Occupation: _____

Physician: _____

Referred By: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Massage Information:

Have you ever received professional massage/bodywork before?

___ Yes ___ No

Do you have a preferred pressure?

___ Light ___ Medium ___ Deep

What are your goals/expectations for receiving massage?

On a scale of 0 to 10, with 0 being the lowest and 10 being the highest, how would you rate your pain now?

0 1 2 3 4 5 6 7 8 9 10

Does your pain prevent you from activities of daily living?
(e.g. sleep, exercise, work, childcare)

Please list medications you are currently taking:

Health History

Musculoskeletal

- Bone or Joint Disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches
- Osteoporosis

Circulatory

- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

Psychological

- Anxiety/ Stress Syndrome
- Depression

Respiratory

- Breathing Difficulties/Asthma
- Emphysema
- Allergies
- Sinus Problems

Nervous System

- Shingles
- Numbness/Tingling
- Pinched Nerve
- Parkinson's Disease

Reproductive

- Pregnant, stage __
- Ovarian/Menstrual Problems
- Prostate

Skin

- Rashes
- Cosmetic, Surgery
- Athlete's Foot

___ Herpes/ Cold sores

Digestive

- ___ Irritable Bowel Syndrome
- ___ Bladder/ Kidney Ailment
- ___ Colitis
- ___ Crohn's Disease
- ___ Ulcers

Other

- ___ Cancer/ Tumors
- ___ Diabetes
- ___ Drug/ Alcohol/ Tobacco
- ___ Contacts
- ___ Hearing Aids
- ___ Dentures

Have you had any surgeries in the past that may influence today's treatment? _____

Please circle any of the following conditions that you currently have: Blood clots, Infections, Congestive Heart Failure, Pitted Edema, Contagious Diseases

Client Agreement:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/Bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Understanding all of this, I give my consent to receive care.

Client Signature: _____

Date: _____

