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? _____

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 doing any particular movements or activities? (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/Vericose Veins
____Blood Clots
____High/Low Blood Pressure
____Lymphedema
____Thrombosis/Embolism

Respiratory
____Breathing Difficulties/Asthma
____Emphysema
____Allergies
____Sinus Problems

Nervous System
____Shingles
____Numbess/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 Bowl Syndrome
____ Bladder/ Kidney Ailment
____ Colitis
____ Crohn's Disease
____ Ulcers

Psychological
____ Anxiety/ Stress Syndrome
____ Depression

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: _____