Client Intake Information

The information requested below will assist me in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #: _____

Address: _____

E-mail: _____ Occupation: _____

Date of Birth: _____ Referred by: _____

Emergency Contact: _____ Phone #: _____

Please answer the following questions to the best of your knowledge.

Have you received massage therapy before? □ Yes □ No If yes, how often? _____

Primary reason for today's massage? _____

Do you have any allergies to oils, lotions, ointments, fruits, or nuts? □ Yes □ No

If yes, please explain: _____

Are you wearing any of the following? (Check all that apply)

□ Contact Lenses □ Hearing Aid □ Dentures □ Prosthetics

Do you sit for long hours at a workstation, computer, or driving? □ Yes □ No

If yes, please describe: _____

What are your hobbies? _____

What would you say your energy level is on average? □ Low □ Moderate □ High

Describe any physical activities you do on a regular basis (gym, sports, gardening, etc):

_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
□ High blood pressure
□ Low blood pressure
□ Congestive heart failure
□ Heart attack
□ Phlebitis/varicose veins
□ stroke/CVA
□ Pacemaker or similar device
□ Heart disease

Respiratory
□ Pneumonia
□ Shortness of breath
□ Bronchitis
□ Asthma
□ Emphysema
□ Chronic cough

Digestion
□ Ulcer
□ Diarrhea
□ Constipation

Infections
□ Hepatitis
□ Skin conditions
□ TB
□ HIV
□ Herpes
□ Athlete's Foot
□ Warts

Other
□ Diabetes
□ Loss of sensation
□ Numbness
□ Tingling
□ Epilepsy
□ Cancer, where? _____
□ Skin conditions, what? _____
□ Arthritis
□ Bursitis

Head/Neck
□ Headaches
□ Migraines
□ Allergies
□ Vision problems/loss
□ Ear problems/hearing loss
□ Thyroid Disease
□ TMJ

Women
□ Pregnant? If yes, how many months? _____
□ Gynecological conditions, what? _____

Psychological
□ Anxiety/Stress
□ Depression
□ Insomnia

Other
□ Drug Use □ Tobacco Use

□ Nausea □ Sciatica □ Alcohol Use How often? _____

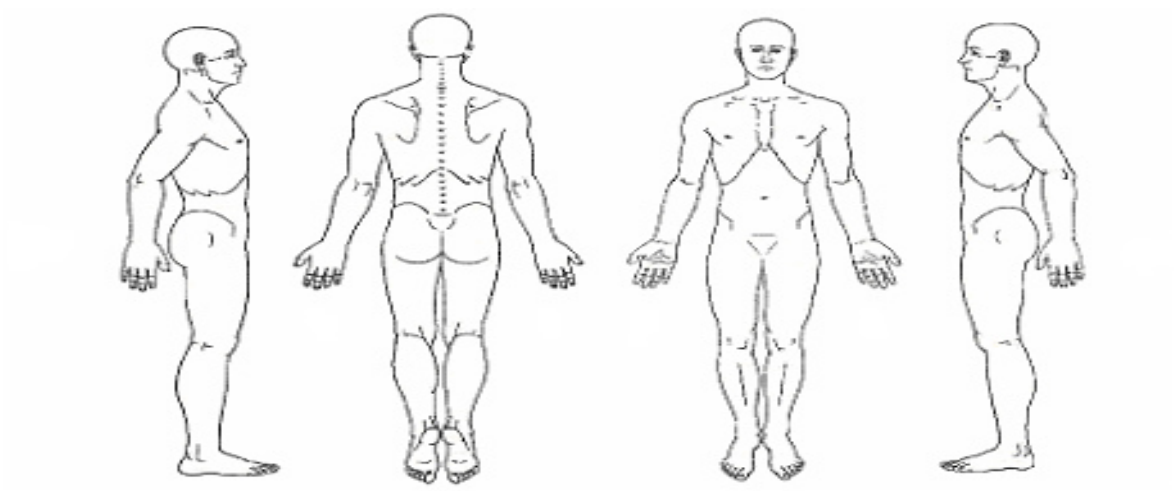
Are you currently under medical supervision? □ Yes □ No If yes, please explain: _____

Do you see a chiropractor? □ Yes □ No If yes, please explain: _____

Are you currently taking any medications? □ Yes □ No If yes, please list: _____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?

_____



Please use an "x" to indicate areas of discomfort.

_____

Please read and sign below:

I, _____ (print name) understand that the massage/bodywork I receive is provided for stress management, reduction of muscular tension, increasing circulation, and developing body awareness. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist'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.

Client Signature: _____ Date: _____