
# Confidential Client Intake Form

## Contact Information:

Name: _____ Date: _____ D/O/B: _____

Address: _____City_____ State:____ Zip code:_____

Phone: _____Email: _____

Occupation: _____

Emergency Contact: Name _____ Phone: _____

How did you hear about us? (Circle) Google Yelp Facebook Friend/Relative Doctor Other

_____

## Massage Therapy Experience:

Have you received professional Massage Therapy or Reiki before? Yes or No

If yes, what did you like most or least about your experience? _____

_____

If yes, how long have you been receiving Massage Therapy or Reiki ? _____

If yes, what types of Massage Therapy have you received? (Swedish, Deep Tissue, Therapeutic, etc?):

_____

Do you enjoy some conversation during your treatment or prefer to savor your quiet time?

_____

Do you have any questions or concerns prior to your treatment today?

_____

## Current Health:

Reason for initial visit: _____

_____

Do you have any current health goals you're working toward? Please share:

_____

_____

How much stress are you currently experiencing? (Circle One) 0-3 Mild 3-6 Moderate 6-10 Excessive

Are you currently exercising? Yes or No If yes, what activities do you participate in?

_____

_____

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

Do you have any specific areas of pain, present or past injuries, trauma or tension that you'd like focused time on?

_____

Do you have any known allergies? Please list: _____

_____

Any additional comments or concerns you'd like to share? _____

_____

## Health History:

**Musculoskeletal**

__Bone or joint disease __Tendonitis/Bursitis

__ Jaw Pain (TMJ) __Lupus __Spinal Problems

__Migraines/Headaches __Osteoporosis

**Respiratory**

__Breathing Difficulty/Asthma __Emphysema

__Allergies __ Sinus Problems

**Digestive**

__Irritable Bowel Syndrome __Bladder/Kidney Ailment

__Colitis __Crohn's Disease __Ulcers

**Reproductive**

__Pregnancy, Week #: ___

__Ovarian/ Menstrual Problems

**Circulatory**

__Heart Condition __Phlebitis/ Varicose Veins

__Blood Clots __ High/ Low Blood Pressure

__ Lymphedema __ Thrombosis/ Embolism

**Nervous System**

__Shingles __Numbness/Tingling

__ Pinched Nerve __Chronic Pain __Paralysis

__Multiple Sclerosis __Parkinson's Disease

**Psychological**

__Anxiety __Depression __PPA/ PPD

__Trauma __Insomnia

__Prostate Cancer

**Skin**

__Acne __Allergies/ Sensitivities

__Rashes __Eczema/ Psoriasis

__Athlete's Foot/Fungus __Herpes/ Cold Sores

**Other**

__Cancer/Tumors __Diabetes

__Drug/Alcohol/Tobacco Use __Contact Lenses

__Dentures __Hearing Aids

**Illness/Disease**

__Cold/ Flu/ Virus __HIV/ AIDS

__Bacterial/Fungal Infection __Lyme Disease

__Tick Borne Illness __Autoimmune Disease

__Chronic Illness __ Covid-19

Any other medical condition(s), illness, or disease not listed:_____

_____

Please explain any of the conditions that you have marked above: _____

_____

Do you take any supplements or medications? Please list:_____

_____

## Women's Health:

Are you currently pregnant? Yes / No If Yes, how many weeks along are you? _____

What is your expected due date? _____

Are you considered to be a high-risk pregnancy? Yes / No

If yes, do you have your Providers permission to receive Massage Therapy? Yes / No

Have you experienced any complications in your pregnancy? _____

Have you reached or are you approaching menopause? Yes / No

If yes, please list any current symptoms: _____

_____

## Client Consent for Care:

I, _____, have completed this form to the best of my knowledge and will inform my massage therapist of any future changes in my physical health. I am over the age of 18 or have parent or guardian permission. I understand that massage therapy is strictly a therapeutic, non-sexual health aide and does not replace medical advice given by my physician. My massage therapist cannot diagnose or prescribe any illness, disease, or any other mental, physical, and or emotional disorder. I am responsible for consulting my physician for any ailments that I may have concerns about. I have taken it upon myself to inform my massage therapist if I experience any pain or discomfort during the session so the treatment can be modified. I have read the practice policies and procedures and agree to these terms. It is my choice to receive massage therapy and I give consent to receive treatment and will consider recommendations to help me achieve my wellness goals.

## Covid-19 Specific Informed Consent

I understand that close contact with people increases the risk of infection from COVID-19. I understand it is not possible to consider every possible complication to care.

I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

**I have read and I agree to the Practice Policies, Consent for Care, and Covid-19 Specific Informed Consent. By signing this form, I acknowledge that I am aware of, assume the risks involved and give consent to receive care from this practitioner.**

_____ _____

(client signature) (date)

Parent/ Legal Guardian Signature (if client is under the age of 18):

_____ _____

(signature) (date)