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

____

Would you like to be added to our e-mail list where we keep you updated of appointment openings, latest news, events, and send helpful health tips? Yes / No

Massage Therapy Experience:

Have you received professional massage therapy 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? _________________________________

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 If Yes, describe:

____

Do you have any specific areas of pain, present/ past injuries, or tension that you'd like to focus on today?

____

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
__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

Respiratory
__Breathing Difficulty/Asthma
__Emphysema
__Allergies
__ Sinus Problems

Nervous System
__Shingles
__Numbness/Tingling
__Pinched Nerve
__Chronic Pain
__Paralysis
__Multiple Sclerosis
__Parkinson's Disease

Reproductive
__Pregnant, Week: ___
__Ovarian/ Menstrual Problems
__Prostate

Psychological
__Anxiety/ Stress
__Depression
__Trauma
__Insomnia

Digestive
__Irritable Bowel Syndrome
__Bladder/Kidney Ailment
__Colitis
__Crohn's Disease
__Ulcers

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

Skin
__Acne
__Allergies/ Sensitivities
__Rashes
__Eczema/ Psoriasis
__Cosmetic Surgery
__Athlete's Foot/Fungus
__Herpes/ Cold Sores

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:_____________________________________

____

____

Primary Physician: (optional) Name: _________________________ Phone #: _____________________

Do we have your permission to contact your physician if the need should arise? Y / N

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 doctor's permission to receive Massage Therapy? Yes/ No

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.

Client Signature: ____ Date: _________________

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

____ Date: _________________