

Confidential Client Intake Form

Name: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Email Address: _____ Cell Phone #: _____

Occupation: _____ Date of Birth: _____

Who referred you to this office? Name: _____

Phone Book Advertisement Sign Other _____

Marital Status: Single Married Divorced Widowed

Children: Yes No How Many? _____

Name of Spouse/Significant Other: _____

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____

Relationship: _____

Have you had a professional massage session before? Yes No

If yes, how frequently and when was your last session: _____

List other bodywork therapies you've received, (i.e. chiropractic, acupuncture, reiki, etc.):

Describe the exercise activities you do (include frequency): _____

Why are you here for a session today? _____

Are you sensitive or ticklish to touch/pressure in any areas? _____

Are you sensitive to essential oils? _____

List any medications (including aspirin) and nutritional supplements you are taking: _____

Confidential Health History

Check the following conditions that apply to you, past (within the last 5 years) and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- Headaches Frequency: _____
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Circulatory & Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold hands or feet
- Cold sweats
- Swollen ankles
- Varicose veins
- Blood clots
- Stroke
- High Cholesterol
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Skin Allergies
- Athlete's Foot
- Cosmetic surgeries (List)
Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____
- Other: _____

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis Onset: _____
- IBS Onset: _____
- Crohn's Disease Onset: _____
- Colitis Onset: _____
- Other: _____

Nervous System

- Numbness/tingling
- Face Twitches
- Fatigue
- Chronic Pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/Shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis Onset: _____
- Muscular Dystrophy
- Parkinson's Disease Onset: _____
- Spinal cord injury Onset: _____
- Other: _____

Reproductive System

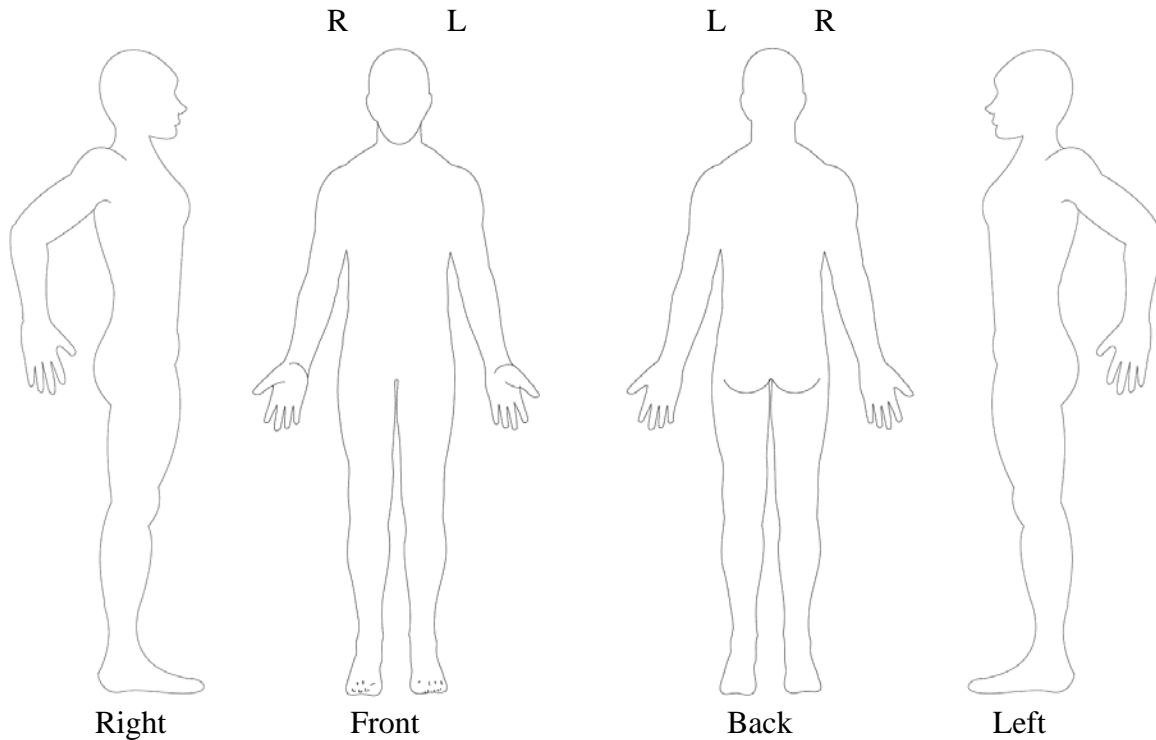
- Pregnancy:
 - Current # Wks: _____
 - Previous #: _____
- PMS Mild Mod. Severe
- Perimenopause Onset: _____
- Menopause Onset: _____
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy Date: _____
- Fertility concerns
- Prostrate problems

Other

- Drug use: _____
- Alcohol use: _____
- Caffeine use: _____
- Nicotine use: _____
- Loss of appetite
- Hearing impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes Onset: _____
- Fibromyalgia Onset: _____
- Post-Polio Syndrome
- Cancer Type: _____
- Hyper/Hypothyroidism Onset: _____
- Hepatitis Onset: _____
- HIV/AIDS Onset: _____
- Other infectious diseases (please list)
_____ Onset: _____
_____ Onset: _____
- Depression
- Other Surgeries (please list)
_____ Date: _____
_____ Date: _____
_____ Date: _____
- Other: _____

Please list any additional comments regarding your health: _____

Please identify current problem areas in your body by drawing circles where pain exists on the diagram below:



Comments: _____

Release Form

I understand that the information I have provided will be held in the strictest confidence and that I have the right to view my records upon written request.

I further understand that the massage/energy therapy I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. 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.

Additionally, I understand that massage/energy therapy 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.

Because massage/energy therapy is contraindicated (should not be done) 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 forget to do so.

Should I need to cancel future sessions, I agree to give my practitioner 24 hours' notice or I will be financially responsible for the session time.

Signed: _____ Date: _____

Practitioner: _____ Date: _____

