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

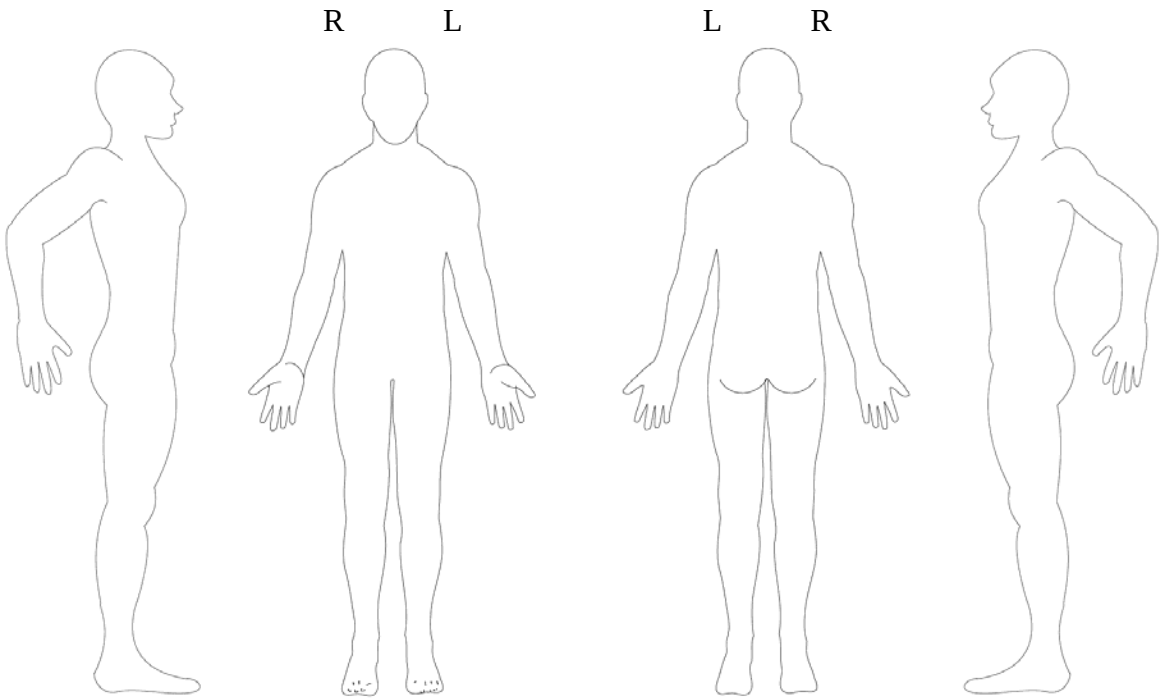
- ☐ Pregnancy:
  - ☐ Current # Wks: _____
  - ☐ Previous #: _____
- ☐ PMS ☐ Mild ☐ Mod. ☐ Severe
- ☐ Perimenopause Onset:
- ☐ Menopause Onset:
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy Date:
- ☐ Fertility concerns
- ☐ Prostrate problems

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: _____

Practitioner's Notes
(Office Use Only)

Health Notes:

Miscellaneous: ☐ GC ☐ 30 ☐ 60 ☐ 90

☐ Essential Oils ☐ Neck Ease ☐ Eye Pillow ☐ Stones ☐ Crystals

Verbal Affirmation: ☐ Yes ☐ No Abdominal: ☐ S ☐ L

Pressure: ☐ H ☐ L ☐ R