

## Client Intake Form Confidential Information

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Best phone number: \_\_\_\_\_ Alternate number: \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone number: \_\_\_\_\_

Have you ever received massage therapy or bodywork? \_\_\_ Yes \_\_\_ No

If yes, how recently? \_\_\_\_\_

Type of massage preferred: \_\_\_\_\_

What are your massage or bodywork goals? (Check all that apply)

\_\_\_ Relaxation \_\_\_ Stress Reduction \_\_\_ Treatment for specific condition Explain:

\_\_\_\_\_

What kind of pressure do you prefer? \_\_\_ Light \_\_\_ Medium \_\_\_ Firm \_\_\_ Not sure

Are you taking medication? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

What is the best way to remind you of future appointments? \_\_\_ Phone call \_\_\_ Text \_\_\_ E-mail

**Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.**

Do you have a history of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Neck pain              | <input type="checkbox"/> Abdominal pain              | <input type="checkbox"/> Colitis                  |
| <input type="checkbox"/> Whiplash               | <input type="checkbox"/> Nervous tension             | <input type="checkbox"/> HIV positive             |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Aneurysm or epilepsy     |
| <input type="checkbox"/> Spine or disk problems | <input type="checkbox"/> Arthritis, bursitis or gout | <input type="checkbox"/> Thrombophlebitis         |
| <input type="checkbox"/> Mid-back pain          | <input type="checkbox"/> Heart attack/problems       | <input type="checkbox"/> Diabetes I or II         |
| <input type="checkbox"/> Low-back pain          | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Joint ache             | <input type="checkbox"/> Decreased range of motion   | <input type="checkbox"/> Respiratory problems     |
| <input type="checkbox"/> Broken bones           | <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Sprains                | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Numbness                 |
| <input type="checkbox"/> Seizures               | <input type="checkbox"/> Varicose veins              | Other:  |

Do you have any of the following today:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Sunburn           | <input type="checkbox"/> Open cuts, bruises, burns | <input type="checkbox"/> Foot fungus       |
| <input type="checkbox"/> Inflammation      | <input type="checkbox"/> Irritated skin rash       | <input type="checkbox"/> Excessively tired |
| <input type="checkbox"/> Severe pain       | <input type="checkbox"/> Poison ivy/oak            | <input type="checkbox"/> Stress            |
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Cold/flu                  | <input type="checkbox"/> Fever/infection   |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Injury                    | <input type="checkbox"/> Pregnant          |

Please list any surgeries or major accidents and the year it happened:

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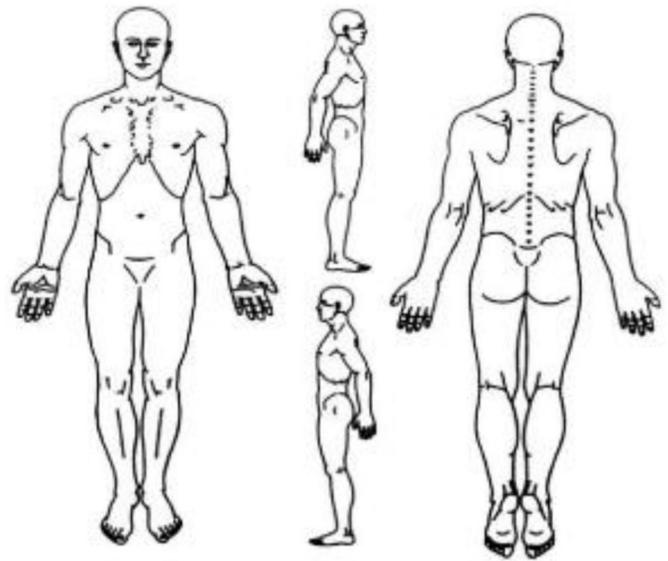
Of special note: (hearing aids, contact lenses, dentures, pacemaker, other special equipment)

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Please list any areas of your body you do not wish to be touched (there will be no contact with your breasts or genitals): \_\_\_\_\_

Any other issues you would like the therapist to be aware of: \_\_\_\_\_

Please indicate with an 'X' on the picture the places you are feeling discomfort:



**Consent for massage and/or bodywork. Please read the following and sign below:**

- I agree to inform my practitioner if I become pregnant, change medications or get an implanted device.
- I understand that this massage or myofascial release session is not a replacement for medical care and that no diagnosis will be made. It is recommended a physician be seen for any ailment I might have.
- I am responsible for paying for any appointment cancellations of less than 24 hours.
- I will disrobe to my comfort level. If at any time I am uncomfortable with the pressure or technique being used, I can/will ask the practitioner to make the necessary adjustment or stop the treatment.
- I understand that this is nonsexual therapeutic bodywork.
- I understand that massage/bodywork should not be performed under certain medical conditions and I affirm that I have stated all of my known medical conditions. I agree to keep the practitioner updated as to any changes in my health and medications and understand that there shall be no liability on the practitioners part should I fail to do so.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Your privacy and confidentiality are respected and valued. Neither your information nor treatment will be discussed without your prior written consent.*