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 bodywork? ___ Yes ___ No

What are your 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: _____

What is the quality of your sleep:

___ Great (few issues) ___Average (occasional issues) ___ Poor (many issues)

What is the quality of your digestion?

___ Great (few issues) ___Average (occasional issues) ___ Poor (many issues)

How did you hear about us? _____

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

Do you currently or in the past have any of the following:

- o Neck pain
- o Whiplash
- o Headaches
- o Spine or disk problems
- o Upper back pain
- o Mid-back pain
- o Low-back pain
- o Joint ache
- o Broken bones
- o Sprains
- o Vertigo
- o Hypo or Hyperglycemia
- o cardiac issues (pacemaker, arrhythmia)
- o Abdominal pain
- o Nervous tension
- o Osteoporosis
- o Arthritis, bursitis or gout
- o Varicose veins
- o Heart attack/problems
- o Cancer
- o Decreased range of motion
- o Fibromyalgia
- o High/low blood pressure
- o Detached retina
- o Knee issues
- o Epilepsy

Other:

- o Colitis
- o HIV positive
- o Aneurysm or epilepsy
- o Thrombophlebitis
- o Numbness
- o Diabetes I or II
- o Chronic Fatigue Syndrome
- o Respiratory problems
- o Stroke
- o Seizures

Glaucoma

- o Depression (Circle one)

Mild, moderate or severe

(over)

Do you have any of the following today:

- o Sunburn
- o Inflammation
- o Severe pain
- o Headache
- o Numbness/tingling
- o Open cuts, bruises, burns
- o Irritated skin rash
- o Poison ivy/oak
- o Cold/flu
- o Injury
- o Foot fungus
- o Excessively tired
- o Stress
- o Fever/infection
- o Pregnant

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

_____

_____

_____

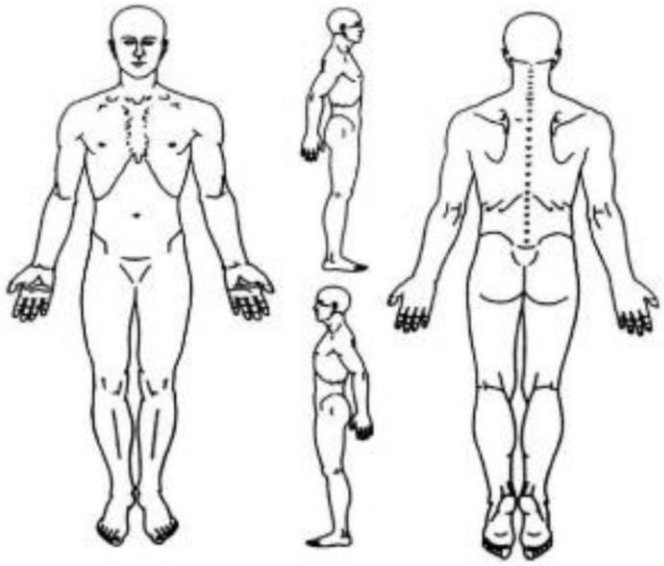
Of special note: (hearing aids, contact lenses, dentures, other special equipment)

_____

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 bodywork. Please read/mark the following and sign below:

- o I agree to inform my practitioner if I become pregnant, change medications or get an implanted device.
- o I understand that this bodywork 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.
- o I am responsible for paying for any appointment cancellations of less than 24 hours.
- o I will disrobe to my comfort level. If at any time I am uncomfortable with the pressure or technique being used, I can and will ask the practitioner to make the necessary adjustment or stop the treatment.
- o I understand that this is nonsexual therapeutic bodywork.
- o I understand that 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.