Therapeutic Effects
Therapy For Body And Mind

MASSAGE / BODYWORK CLIENT INTAKE FORM ... page 1 of 3

Name _____ Date _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone: (Home) _____ (Work) _____ (Cell) _____ E-mail _____

Occupation: _____ Work Activities (sitting, standing, lifting, computer, etc.): _____

Emergency Contact: _____ Phone (H) _____ (W) _____ (C) _____

Referred by: ☐ Friend ☐ Healthcare Provider ☐ Advertising ☐ Flyer/Brochure ☐ Internet ☐ Other

TODAY'S SESSION

Have you received massage therapy before? ☐ Yes ☐ No How was the experience? _____

Reason for today's visit? _____ Desired outcome/result: _____

Is this concern: ☐ Minor ☐ Problematic ☐ Major Is it: ☐ Recurring ☐ Chronic ☐ Getting Better ☐ Getting worse

Explain: _____

Have you ever received treatment or therapy for this before? ☐ Yes ☐ No Explain: _____

Are any of your activities affected? ☐ Yes ☐ No Explain: _____

Any other concerns today? ☐ Yes ☐ No Explain: _____

Stress reduction/Exercise activities: _____ Frequency: _____

Current medications (include over-the-counter, herbal, etc.): _____

Any allergies? ☐ Yes ☐ No List: _____

CHECK, CIRCLE & EXPLAIN ANY OF THE FOLLOWING THAT APPLY TO YOU

- Skin condition (acne, rash, bruise, bite, scrape, cut, other). Explain. _____
- Lymphatic condition (swollen glands, lymphoma, lymphederma, other). Explain. _____
- Recent injury or accident (whiplash, sprain, deep bruise, broken bone, other). Explain. _____
- Circulatory or heart condition (heart disease, angina, varicose veins, phlebitis, arrhythmia, arteriosclerosis, history of deep vein thrombosis, history of embolism, other). Explain. _____
- Diabetes. Diminished sensation. Neuralgia. Explain. _____
- Neurological condition (sciatica, numbness/tingling, stroke, epilepsy, multiple sclerosis, TBI, seizure, other). Explain. _____

_____

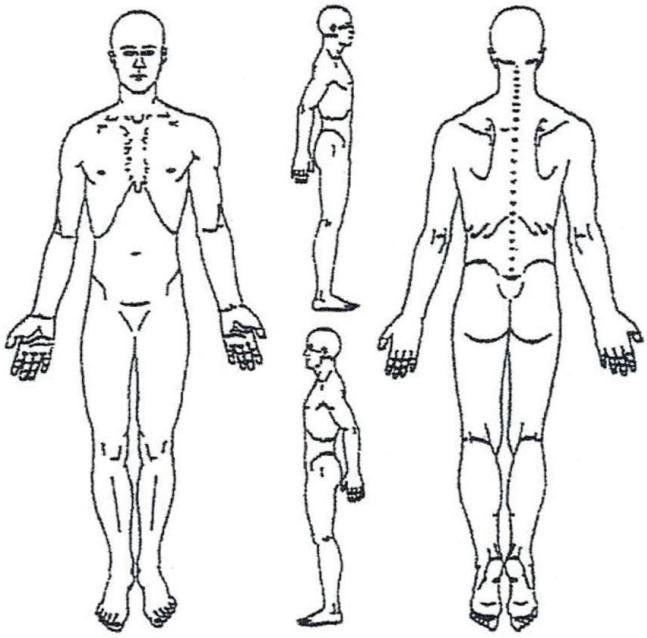
- Joint problems / pain / stiffness (osteoarthritis, rheumatoid arthritis, gout, hyper-mobile joints, sacroiliac problems, other). Explain.

_____

- Bone condition (osteoporosis, osteopoenia, previous fracture, other). Explain. _____
- Headaches (migraines, PMS, tension, cluster, other). Explain. _____
- Emotional difficulties (depression, anxiety, psychotic episodes, other). Explain. _____
- Fibromyalgia. Explain. _____
- Stress. Explain. _____
- Recent surgery / previous surgery. Explain. _____
- Current cancer / previous cancer. Explain. _____
- Are you / is there any possibility that you are pregnant? _____ Month? _____ Concerns: _____
- Other medical condition. Explain. _____

Note all areas of discomfort on these figures or below:

Pain or tenderness... mark with OO's
Numbness or tingling... mark with ZZ's
Swelling or stiffness... mark with XX's
Scars, bruises, or open wounds... mark with HH's



Note your symptom areas & rate severity from 1-10
1 = no pain 10 = extreme pain

Front
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Back
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Right
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Left
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

PREVIOUS HISTORY Please give dates (year) or age (years ago) for each item.

Surgeries: _____

Accidents: _____

Major Illnesses: _____

OTHER INFORMATION

Primary Care Provider _____ Phone _____

Address _____ City _____ State _____ Zip _____

Do we have permission to contact your health care provider should the need arise? ☐ Yes ☐ No

Do you have any allergies/sensitivities? ☐ oils ☐ lotions ☐ scents ☐ detergents ☐ foods ☐ animals ☐ plants ☐ other

Explain. _____

Is there anything else we should know to ensure your comfort?

- Contact lenses (the face pillow may put pressure on your eyes): _____
- Hearing concerns (communication is helpful during the session): _____
- Hair / make-up / clothing (will you return to work or go to an event after your session?): _____
- Movement difficulties (do you need help getting on or off the table or turning over?): _____
- Are you ticklish? _____ feet? _____ elsewhere? _____
- Is there any place on your body that you would prefer not to receive massage? _____
- Is there anything else that you would like us to know? _____

CONSENT FOR CARE

I acknowledge that it is my choice to receive Massage Therapy.

I acknowledge that the Massage Therapist will not be responsible for any injury sustained because of any condition or concern that I have forgotten or failed to disclose.

I understand that there is no implied or state guarantee of success or effectiveness of an individual technique or session.

I understand that late arrivals might not receive an extension of scheduled service time and that I may be responsible for full service fees.

I understand that Massage Therapy is not a substitute for medical care or treatment, and that it is recommended that I work accordingly with my Primary Care Provider for any medical condition, actual or possible, that I have or may have.

I acknowledge that I have been given the opportunity to ask questions before receiving any work, and that I may question or interrupt the work at any point after the session begins.

If I experience any pain or discomfort during the session, I will immediately communicate this to the Massage Therapist.

I acknowledge that I have read and understood this document.

CLIENT'S SIGNATURE _____ DATE _____

PLEASE PRINT YOUR FULL NAME _____

ANNUAL HEALTH HISTORY UPDATE

You will be asked to complete a health history on a yearly basis.

It is imperative that you inform your therapist of any medical changes at the beginning of each session.

If at any time the Massage Therapist ascertains that massage or bodywork is contraindicated, you may need to provide a note from your physician clearing you to return to receiving Massage Therapy or bodywork..

CLIENT'S SIGNATURE _____ DATE _____

PLEASE PRINT YOUR FULL NAME _____