

CLIENT INTAKE

Client Name (please print) _____ Date _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Date of Birth _____ Pronouns _____
Telephone (day) _____ Telephone (evening) _____ Email _____
Emergency Contact _____ Telephone _____
Insurance _____ Physician _____

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.

What are your typical daily activities – work, home, exercise? _____
What substances are you currently taking? (prescription, herbs, supplements, alcohol, recreational drugs, over-the-counter) _____
Have you ever received massage? _____ When? _____ Why? _____
What was the outcome? _____
What are your current goals for massage? _____
What level of pressure do you prefer? _ light _ medium _ firm

Current Health Concerns

Concern #1

Severity	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Frequency	<input type="checkbox"/> constant	<input type="checkbox"/> intermittent	
Symptoms	<input type="checkbox"/> ↑ with activity	<input type="checkbox"/> ↓ with activity	
Changes	<input type="checkbox"/> getting worse	<input type="checkbox"/> getting better	<input type="checkbox"/> no change

Treatment received _____
Medications _____
Activities Limited by Condition _____
Comments _____

Concern #2

Severity	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Frequency	<input type="checkbox"/> constant	<input type="checkbox"/> intermittent	
Symptoms	<input type="checkbox"/> ↑ with activity	<input type="checkbox"/> ↓ with activity	
Changes	<input type="checkbox"/> getting worse	<input type="checkbox"/> getting better	<input type="checkbox"/> no change

Treatment received _____
Medications _____
Activities Limited by Condition _____
Comments _____

Health History: please provide information for the past 5 years, including type, approximate dates and treatment

Surgeries _____
Major Illnesses _____
Injuries _____

Health Conditions Please circle any **current** and **previous** conditions.

General				Comments
Pain	Numbness	Altered Sensation		_____
Headaches	Fatigue	Sleep Disturbances		_____
Infections	Swelling	Allergies		_____
Skin Conditions				
Abrasions/Cuts	Rashes	Other		_____
Muscles and Joints				
Arthritis	Osteoporosis	Scoliosis		_____
Fractures	Sprains	Strains		_____
Bursitis	Tendonitis	Stiffness		_____
Disk Problems	TMJ	Other		_____
Cardiovascular and Respiratory				
Anemia	Angina	Arteriosclerosis		_____
Heart Attack	Asthma	Congestive Heart Failure		_____
Heart Disease	Hypertension	Irregular Heart Beat		_____
Varicose Veins	Blood Clots	Phlebitis		_____
		Other		_____
Nervous System				
Concussion	Head Injury	Stroke		_____
Anxiety	Depression	Other		_____
Endocrine System				
Type I Diabetes	Type 2 Diabetes	Thyroid	Other	_____
Digestion and Elimination				
Heartburn	Gastric Reflux	Ulcers		_____
Bowel Problems	Gas/Bloating	Urinary Tract Problems		_____
		Other		_____
Reproductive System				
Pregnancy	PMS	Other		_____
Cancer or Tumors				
Benign	Malignant			_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation 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. I further understand that massage or bodywork 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. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed 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 fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____