CLIENT INTAKE

Client Name (please print) _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Sex _____ Preferred Pronoun _____ Preferred Contact Method _____

Telephone (day) _____ Telephone (evening) _____ Email _____

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.

Current Health Concern

Concern Description _____

Severity	□ mild	□ moderate	□ severe
Frequency	□ constant	□ intermittent	
Symptoms	↑ with activity	↓ with activity	
Changes	□ getting worse	□ getting better	□ no change

Treatment received _____

Medications _____

Activities Limited by Condition _____

Comments _____

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 had professional massage before? _____ What level of pressure do you prefer? _ light _ medium _ firm

What are your current goals for massage? _____

Emotional stress scale

0 – No stress / 10 Extremely stressed:

0 1 2 3 4 5 6 7 8 9 10

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	_____
Shunts	Plates	Pints / Rods	_____
Transplant	Dizziness	Fainting	_____
Bruise easily	Aching joints	Allergies	_____
Infections	Swelling	Other	_____

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 _____

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 _____

Insurance Information

If you were in an auto accident, please provide the following information:

Claim Number

_____

Adjuster's Name

_____

Adjuster's Email Address

_____

Adjuster's Phone Number

_____

Adjuster's Fax Number

_____

Insurance Agency & Address

_____

Do you have a prescription for Massage? _____ **Date of Injury (accident)** _____

Primary Insurance

Insured's employer

_____

Gender According to Insurance

_____

Marital Status: Single___ Married___ Partnered___ Other___

Primary Insurance Plan Name

_____

Insurance Phone _____

Group Number

_____

Plan Number

_____

Plan's Billing Address

_____

_____

Apt/Unit #_____

Birth Date _____