Client Intake / Health Information Form

Date: _____

Name: _____ Sex: Male Female

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Date of Birth: _____ Occupation: _____

Employer: _____

Marital status: Single Married

Name of spouse or significant other: _____

Children's names and ages: _____

Who referred you to this office? Name: _____

☐ Yellow Pages ☐ Advertisement ☐ Sign ☐ Other: _____

Preferred appointment day and time: _____

Have you ever had a professional bodywork session before? Yes No

If yes, when and what type? _____

In case of emergency, please notify: _____

Relationship: _____ Phone: _____

Primary health care provider: _____

Provider's phone: _____ Extension: _____

Permission to consult with primary health care provider: Yes No _____ *(if yes, please initial)*

Present symptoms: What is your major complaint or condition you want to improve? _____

_____

When did you first notice major complaint(s)? _____

_____

What brought it on? _____

What activities aggravates this condition? _____

Is this condition getting progressively worse? Yes No

Please explain: _____

Does this condition interfere with work? Y N Sleep? Y N Daily routine? Y N

Please explain: _____

What have you done to get relief? _____

Has there been a medical diagnosis? Yes No

If yes, by whom? _____

Please explain: _____

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Have you had X-rays taken for this condition? Yes No

If yes, by whom?_____

Are you now under medical / therapeutic treatment for this condition? Yes No

If yes, what type?_____

List any medications *(including aspirin)* and nutritional supplements you are taking:_____

_____

Describe the exercise activities you do (*include frequency*):_____

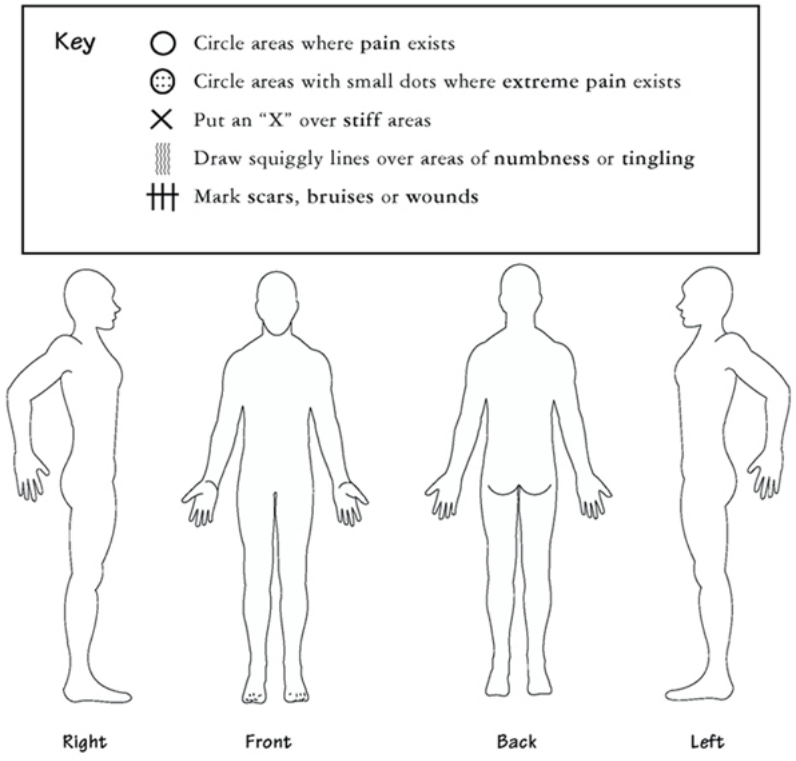
_____

Please list *(date and description)* any accidents or operations:_____

_____

Current Problem Areas

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.



Additional comments:

_____

_____

_____

Client Signature:_____ Date: _____

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal
- ❑ Headaches
- ❑ Joint stiffness/swelling
- ❑ Spasms/cramps
- ❑ Broken/fractured bones
- ❑ Strains/sprains
- ❑ Back, hip pain
- ❑ Shoulder, neck, arm, hand pain
- ❑ Leg, foot pain
- ❑ Chest, ribs, abdominal pain
- ❑ Problems walking
- ❑ Jaw pain/TMJ
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bone or joint disease
- ❑ Other: _____

Circulatory and Respiratory
- ❑ Dizziness
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Pressure sores
- ❑ Varicose veins
- ❑ Blood clots
- ❑ Stroke
- ❑ Heart condition
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Lymphedema
- ❑ Other: _____

Skin
- ❑ Rashes
- ❑ Allergies
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Moles
- ❑ Acne
- ❑ Cosmetic surgery
- ❑ Other: _____

Digestive
- ❑ Nervous stomach
- ❑ Indigestion
- ❑ Constipation
- ❑ Intestinal gas/bloating
- ❑ Diarrhea
- ❑ Diverticulitis
- ❑ Irritable bowel syndrome
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Adaptive aids
- ❑ Other: _____

Nervous System
- ❑ Numbness/tingling
- ❑ Twitching of face
- ❑ Fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Herpes/shingles
- ❑ Cerebral Palsy
- ❑ Epilepsy
- ❑ Chronic Fatigue Syndrome
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Parkinson's disease
- ❑ Spinal cord injury
- ❑ Other:_____

Reproductive System
- ❑ Pregnancy:
  - ❑ Current ❑ Previous
- ❑ PMS
- ❑ Menopause
- ❑ Pelvic Inflammatory Disease
- ❑ Endometriosis
- ❑ Hysterectomy
- ❑ Fertility concerns
- ❑ Prostrate problems

Other
- ❑ Loss of appetite
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Difficulty concentrating
- ❑ Drug use _____
- ❑ Alcohol use _____
- ❑ Nicotine use _____
- ❑ Caffeine use _____
- ❑ Hearing impaired
- ❑ Visually impaired
- ❑ Burning upon urination
- ❑ Bladder infection
- ❑ Eating disorder
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Post/Polio Syndrome
- ❑ Cancer
- ❑ Infectious disease (please list)

  _____
- ❑ Other congential or acquired disabilities (please list)_____

  _____
- ❑ Surgeries _____
- ❑ Other: _____

For clients who need mobility assistance, please give your height: _____ weight: _____

Please list any additional comments regarding your health and well-being: _____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____

Massage Therapy Informed Consent

I, _____ , (client) understand that massage therapy provided by, _____ , (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____

_____

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

I understand and agree to abide by the following policies:
Arrival - You should arrive 15 minutes early to acclimate yourself to our facilities and complete the requisite paperwork before your session begins. We wish to treat all our clients with respect and in a timely manner and any late arrival may unfortunately deprive you of precious time from your session.
Reservations and Cancellation - Your services and treatments are reserved and prepared especially for you. Because of our exclusivity and premium services, a strict cancellation policy will be upheld.
A 50% fee is charged for cancellations and missed appointments without a minimum notice of 24 business hours.

_____ _____

Client Signature Date