

Client Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name _____ Date of birth _____
Address _____ City _____ State ____ Zip _____
Day Phone _____ Email _____
Occupation _____

Have you ever received massage therapy? ___Yes ___No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.)

Are you currently taking any medications? ___Yes ___No If yes, please list name and reason for medications: _____

Are you currently seeing a healthcare professional? ___Yes ___No If yes, please list names and reason/treatment: _____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

- | | |
|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> depression, panic disorder, other psych |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> joint pain |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> diverticulitis |
| <input type="checkbox"/> broken/dislocated bones | <input type="checkbox"/> headaches |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> heart conditions |
| <input type="checkbox"/> cancer | <input type="checkbox"/> back problems |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> constipation/diarrhea | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> auto-immune condition* | <input type="checkbox"/> muscle strain/sprain |
| <input type="checkbox"/> hepatitis (A, B, C, other) | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> skin conditions | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> stroke | <input type="checkbox"/> seizures |
| <input type="checkbox"/> surgery | <input type="checkbox"/> whiplash |
| <input type="checkbox"/> TMJ disorder | <input type="checkbox"/> chemical dependency (alcohol, drugs) |

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so: _____

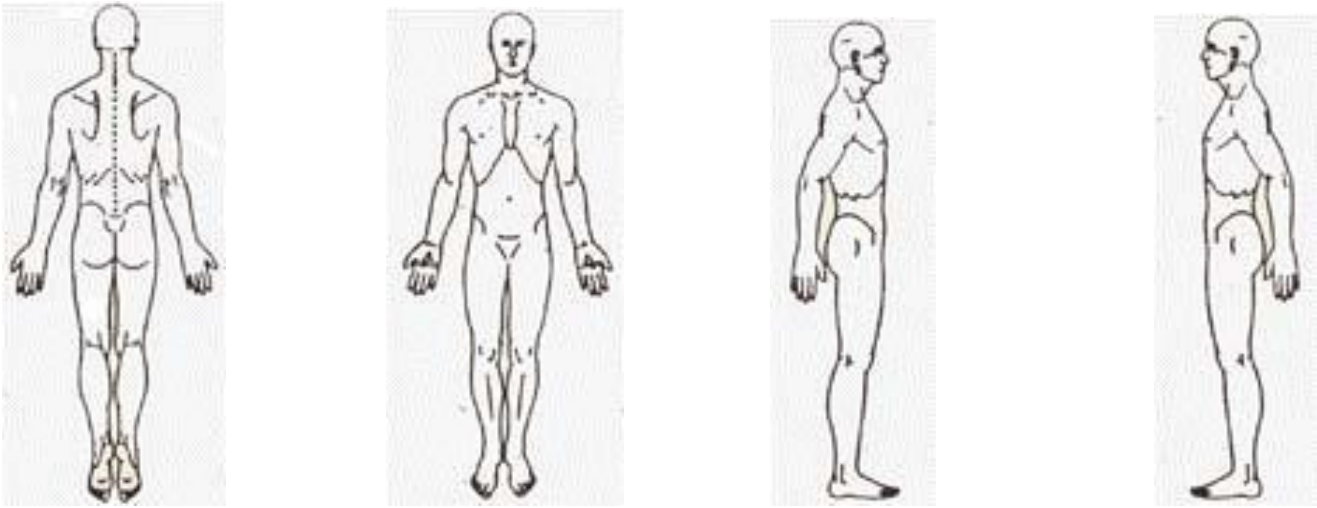
Do you have any of the following today: ___skin ___rash ___cold/flu ___open cuts
___severe pain ___contagious injuries/bruises/cuts

Do you have any allergies: ___medications ___foods (nuts,etc.) _____
___dust, pollen, fragrances, lotions, liquids, skin/hair care products

If any of the above are checked, please give details: _____

Are you wearing: ___contact lenses ___hearing aid ___hairpiece ___pacemaker

Please indicate with an (X), if any, the areas in which you are feeling discomfort/pain:



What are your goals/expectations for this therapy session? _____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs: need to move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or movement of intestinal gas, energy shifts, falling asleep and snoring.

Please read the following information and sign below:

I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

This is a therapeutic massage and any sexual remarks or advances will terminate the session.

Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____