Client Intake Form

Date:_____ Referred by:_____

Name:_____ ☐ Male ☐ Female

Address:_____

City: _____State: _____Zip:_____

Best Phone to contact #: _____ Alternative Phone #:_____

Email:_____ ☐ Appointment Confirmation/Reminder ☐ Opt-In to Newsletter

Date of Birth: _____ Occupation:_____

Employer: _____

Marital status: ☐ Single ☐ Married Name of Spouse/Significant Other:_____

Children's Names and Ages: _____

Preferred Appointment Time:_____

Primary Health Care Provider _____

City: _____ State: _____Zip: _____

Telephone #: _____ Extension: _____

Permission to Consult with Primary Provider? ☐ No ☐Yes _____ (please initial if yes)

Chiropractor::_____How often?_____

Physical Therapist:_____ Medical Center:_____

In Case of Emergency, Please Notify:

Name: _____Telephone #:_____

Relationship:_____

Health History

Medications/Use _____

_____

_____

_____

Check the following conditions that apply to you presently. Please add your comments to clarify the condition.

Musculo-Skeletal
- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ 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
- ☐ Other:

Circulatory and Respiratory
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ 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
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Other:

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

Reproductive System
- ☐ Current Pregnancy:
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems

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

_ _____

- ☐ Past Surgeries -

_____

_____

_____

_____

Please use extra paper to explain more details of current or past conditions.

Client Intials:_____

Massage Therapy Informed Consent

I, _____ , (client) understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

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.

Client Signature _____ Date:_____

Policies:

Cancellations:

Your business is valued and your cooperation is appreciated .We are making a commitment to you to guarantee your appointment time and refusing all other requests once you have made the appointment. A 24-hour cancellation notice is required for any scheduled appointments including gift certificate sessions. Missed or no-show appointments will result in your being charged the full amount of the session booked unless the appointment can be filled. Depending on our booking schedule, late appointments may not receive the full session time allotted for the treatment service booked: Full payment is required.. Emergency cancellations are determined by the Massage Therapist discretion.

Client Signature _____ Date:_____