Client intake form

Personal Information Date: _____

Name: _____ Date of Birth: _____

Address:_____
City State Zip

Home Phone/Cell Phone: _____ E-mail: _____

Occupation: _____ Employer: _____

Name of Spouse/Significant Other: _____ Marital Status: Single Married

Preferred Appointment Day and Time: _____

Preferred Reminder Method: Text Phone Call E-mail

Referred by: Name: _____ Facebook Website Google Other: _____

Emergency Contact Name (relationship): _____Phone: _____

Healthcare Provider: _____ Phone: _____

Massage Experience

Have you had a professional massage before? Yes / No If yes, what types of massage have you had (Swedish, shiatsu, deep tissue, etc)? _____

How long have you been receiving massage therapy? _____Frequency? _____

What are your goals for treatment? _____

Current Health

Reason for initial visit _____

When did you first notice major complaints? _____

What brought it on? _____

What activities aggravate the condition? _____

Is this condition getting progressively worse? Yes / No

Please Explain: _____

Does this condition interfere with work? Yes / No Sleep? Yes / No Daily Routine? Yes / No

Please Explain: _____

What have you done to get relief? _____

Has there been a medical diagnosis? Yes / No If so, by whom? _____

Please Explain: _____

Are you now under medical/therapeutic treatment? Yes / No

If yes, for what condition? _____

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

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

_____

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

_____

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

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

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

Skin
- o Rashes
- o Allergies, specify: _____
- o Athlete's Foot
- o Warts
- o Acne
- o Cosmetic surgery
- o Herpes/Cold Sores
- o Other: _____

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

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

Reproductive System
- o Pregnancy: Previous / Current Trimester_____
- o PMS
- o Menopause
- o Pelvic Inflammatory Disease
- o Endometriosis
- o Hysterectomy
- o Fertility concerns
- o Prostate problems

Other
- o Loss of appetite
- o Forgetfulness
- o Confusion
- o Depression
- o Difficulty concentrating
- o Drug/Alcohol/Tobacco Use
- o Hearing impaired
- o Visually impaired
- o Burning upon urination
- o Bladder infection
- o Eating disorder
- o Diabetes
- o Fibromyalgia
- o Post/Polio Syndrome
- o Cancer
- o Infectious disease (please list) _____ _____
- o Other congenital or acquired disabilities (please list) _____ _____
- o Other _____

Do you have sensitive skin? _____ Do you have any allergies to oils, lotions or ointments? _____

If yes, please explain _____

Please list any additional comments regarding your health and wellbeing: _____

_____

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: _____