Today's Date: _____ Client Intake Form

Full Legal Name: _____ Phone: (____)_____

Address: _____ Cell Phone: (____)_____

City/State/Zip: _____ Y__ N__ (is it ok to text this number?)

Email Address: _____ Date of Birth: _____..

Emergency Contact: Name: _____ Phone: (____)_____

Best way to reach you: H phone ___ W phone ___ C Phone ___ Address ___ E-mail ___

Height: _____ Weight: _____ Age: _____ Sex: _____ Marital Status: _____

Date of Injury/Accident: _____ Primary Care Physician: _____

Currently under a physician's care? Yes No | For Pain? Yes No Other? _____

If yes, name of Physician: _____ Diagnosis given: _____

Current Treatment(s): _____

_____

Referred by physician? Yes No If no, who referred you? _____

Check all you have consulted for your symptoms:

___Physician	___Medical Dr.	___Physical Therapist
___Naturopath	___Dr. of Osteopathy	___Occupational Therapist
___Neurologist	___Dr. of Chiropractic	___Massage Therapist
___Orthopedist	___Psychiatrist	___Acupuncturist
___Psychologist	___Counselor	___Biofeedback

___Other (Specify): _____

List past surgeries and dates:_____

_____

List all medication(s) you are currently taking including over-the-counter such as asprin:

	Medication	Dosage	Frequency	Effectiveness
1.				
2.				
3.				
4.				

List all vitamins and supplements you are currently taking: _____

_____

List all **allergies** including food, medications, seasonal, etc: _____

_____

Are you now OR do you suspect you are pregnant? Yes No

Please check any or all that apply to you:

Right Handed: _____ Left Handed: _____

1) What are your hopes for this session?
   Relaxation ____ Injury/Accident Relief____ Headaches Relief ____ Nothing else works ___
   Seeking this before surgery ___ Chronic Condition/Other (Specify):_____
   _____

2) Rate your area(s) of **current** pain by circling the number on the scale of "0" (no pain) to "10" (worst pain possible):

Low Back – 0 1 2 3 4 5 6 7 8 9 10
Middle Back – 0 1 2 3 4 5 6 7 8 9 10
Upper Back – 0 1 2 3 4 5 6 7 8 9 10
Neck – 0 1 2 3 4 5 6 7 8 9 10
Headache – 0 1 2 3 4 5 6 7 8 9 10
Face – 0 1 2 3 4 5 6 7 8 9 10
Chest – 0 1 2 3 4 5 6 7 8 9 10
Abdomen – 0 1 2 3 4 5 6 7 8 9 10
Groin – 0 1 2 3 4 5 6 7 8 9 10
Other (specify) – 0 1 2 3 4 5 6 7 8 9 10

Right Shoulder – 0 1 2 3 4 5 6 7 8 9 10
Left Shoulder – 0 1 2 3 4 5 6 7 8 9 10
Right Arm or Elbow – 0 1 2 3 4 5 6 7 8 9 10
Left Arm or Elbow – 0 1 2 3 4 5 6 7 8 9 10
Right Hand or Wrist – 0 1 2 3 4 5 6 7 8 9 10
Left Hand or Wrist – 0 1 2 3 4 5 6 7 8 9 10
Right Hip or Knee – 0 1 2 3 4 5 6 7 8 9 10
Left Hip or Knee – 0 1 2 3 4 5 6 7 8 9 10
Right Leg or Foot – 0 1 2 3 4 5 6 7 8 9 10
Left Leg or Foot – 0 1 2 3 4 5 6 7 8 9 10

3) Briefly describe your symptoms and include when they began: _____
   _____

If headaches are a main area of complaint, check all that apply in questions 6-10.

4) **How often** do you get headaches?
   ___Daily
   ___Every Other Day
   ___Once a Week
   ___Once a Month
   ___Twice a Month
   ___Sporadically
   ___Rarely

5) **How long** do your headaches last?
   ___Hours (Specify):
   ___One Day
   ___Two Days
   ___Three Days
   ___Four Days
   ___Longer than four days
   ___They Never go Away

6) Where in your body do you **first** feel your headache?
   ___Forehead ___Behind Your Eyes ___Middle Back
   ___Neck ___Behind One Eye ___Upper Back/Shoulders
   ___Jaw ___Ear (Right or Left) ___Other (Specify):

7) How would you **describe** your headache?
   ___A vice around your head ___Pressure from the inside pushing outward
   ___Forehead pressure ___Pressure pushing on lef or right side of face
   ___Earache ___Bright lights followed by extreme pain
   ___Other (Specify):

8) What time of day do you **first** notice your headache?
   ___Upon first waking ___Early afternoon
   ___After getting out of bed ___Late afternoon
   ___Mid-morning ___Early evening __Other (Specify):

9) Check Yes or No to the conditions/symptoms for which you **have been** or are **currently** being treated:
(Note: One line may be drawn down the N Space if after reading, you don't have any of the conditions listed)

Skin Conditions:
Y__ N__ Eczema
Y__ N__ Cancer
Y__ N__ Herpes
Y__ N__ Psoriasis
Y__ N__ Athlete's foot
Y__ N__ Ring Worm
Y__ N__ Acne
Y__ N__ Burns
Y__ N__ Other (specify):

Y__ N__ Diabetes(Type 1or2)
Y__ N__ (Other Disease/Condition)_____

Nervous System Conditions:
Y__ N__ Multiple Sclerosis
Y__ N__ Sciatica
Y__ N__ Neuroma
Y__ N__ Neuritis/Neuropathy
Y__ N__ Neuralgia
Y__ N__ Pinched Nerve
Y__ N__ Numbness/Loss of Sensation
Y__ N__ Bulging Disk
Y__ N__ Ruptured Disk
Y__ N__ Other (Specify):

Circulatory Conditions:
Y__ N__ Blood Clots
Y__ N__ Varicosities
Y__ N__ H/L Blood Pressure
Y__ N__ ❤ ConditionPacemaker
Y__ N__ Other (Specify):

Surgeries:
Y__ N__ Hernia Surgery
Y__ N__ Stomach Banding
Y__ N__ Gall Bladder Surgery
Y__ N__ Hysterectomy
Y__ N__ Vasectomy
Y__ N__ Other (Specify):

Osteopathic Conditions:
Y__ N__ Degenerative hip/shoulder/knee
Y__ N__ Joint Replacement (Specify: What joint and How long ago):
Y__ N__ Other (Specify):

Y__ N__ Acute Stroke
Y__ N__ Brain Tumors
Y__ N__ Cerebral Hemorrhage
Y__ N__ Skull Fracture (When)
Y__ N__ Cerebral Aneurysm
Y__ N__ Clots

Y__ N__ Any other serious condition in which fluid-pressure changes within the skull. (Specify)

10) **Any other Disease, Disorder, Condition** etc. that you **have been** or are **currently** experiencing:

_____
_____
_____

11) Check all that apply (more extreme things you have experienced in the past or are currently experiencing):

___Anxiety
___ Depression
___Phobia(s)
___Physical Abuse
___Mental Abuse
___Fear
___Trapped Feeling
___Trauma
___Lethargic
___Other (Specify):

___Stress
___Fatigue
___Social Anxiety
___Lack Self Confidence
___Weight Issues
___Eating Disorder(s)
___Rejected
___Death of a loved one
___Frequently Sick

___Anger
___Guilt
___Betrayed
___Demotivated
___Cravings (Food/Cigarette/etc)
___Jealousy
___Shame
___Low Self-Esteem

Notes, Comments, anything else you wish to communicate with me:

_____
_____
_____

Thank you!

Client Agreement Form and Policies

Please initial each line and sign at the bottom. Thank you!

_____ I am aware that this is a non-sexual massage. Any form of misconduct or inappropriate behavior will immediately terminate the massage with full payment due.

_____ I understand that if I disrobe, I will be fully covered, (known as a "drape") excluding the body part that the therapist will be working on. I also understand that my therapist will position the drape so that is the most comfortable and that I do not need to touch the drape at all during the massage. The therapist will discuss any draping procedures that include the gluteal and/or the abdomen area with me prior to the session if that is an area in which I need or ask for during the treatment.

_____ I understand that the therapist does not diagnose, prescribe, or treat any illness, ailment, or disease. I understand that the therapist does not "fix" me. I understand that even though my symptoms or ailments may be “gone” after treatments, I still need to talk to my doctor and should never stop my medication without talking to my doctor first. I also understand that the therapist may assist at my discretion in relief of physical or emotional symptoms that could occur during the massage as traumas are held in the body and could be released.

_____ I understand that Massage, Structural Relief Therapy, CranioSacral Therapy, Visceral Manipulation, Massage Cupping, and all other treatments done by this therapist include but is not limited to, stress reduction, emotional release, relaxation, breaking up of fascia and scar tissue, and relief of muscular tension or spasm, and is not a substitute for medical treatments, or exams.

_____ I understand that I need to let my therapist know of any medical conditions *and* any medical changes in my health I also understand that I may need to get written permission from my doctor, for my therapist to proceed with sessions.

_____ I understand that I am to come to my massage session with proper hygene.

_____ I understand that 24 hour notice of cancellation is required: otherwise I will be required to pay the full amount for either a late cancellation or a missed appointment as others could have had that timeslot.

_____ I agree to pay cash, credit/debit, or check after the session. If my check bounces, I agree a $20.00 service fee, as well as any additional fines the therapist may incur as a result.

_____ By signing below I affirm that all I have said is accurate, I am who I say I am and I affirm that everything I have said in this form is completely true and accurate. I understand that this form will remain confidential to the extent of the law.

_____ _____

Client Signature Today's Date

_____

Parent or Guardian PRINT NAME (If client is under the age of 18)

_____ _____

Parent or Guardian SIGNATURE (If client is under the age of 18) Today’s Date

_____ _____

Massage Therapist's Signature Today's Date