Client In-Take Form

General Information

Name	Date of birth	Today's date
Street address	Occupation	Home phone
City/State/Zip	E-mail	Work phone
Emergency contact and phone	Referred by	Cell phone

Health Care Information

Primary health care provider	Other provider and modality
Telephone	Telephone
Current diagnosis or treatment	Current diagnosis or treatment

May I consult with your health care provider(s) if/when you and I feel it would be helpful? Please initial: Yes____ No____

Current Medications (prescription, over-the-counter, and herbal)

Personal Medical History (Please ***(Circle)*** conditions experienced with the last 12 months and ***(Underline)*** older conditions; please indicate ***where in your body*** you are experiencing the condition.

Skeletal broken/fractured bone _____ bursitis _____ arthritis _____ tendonitis _____
osteoporosis_____ other _____

Muscular sprain/strain _____ spasm/cramp _____ headache neck/shoulder/arm low back/hip/leg
jaw (TMJ) \ fibromyalgia lupus other _____

Circulatory heart condition _____ high/low blood pressure varicose veins blood clots _____
edema _____ lymphedema _____ phlebitis _____ other _____

Digestive constipation diarrhea gas/bloating diverticulitis irritable bowel syndrome indigestion/reflux ulcer
other _____

Nervous System numbness/tingling _____ chronic pain _____ herpes/shingles headache migraine fatigue
sleep disorder carpal tunnel multiple sclerosis Parkinson's other _____

Skin allergy _____ rash _____ warts _____ athlete's foot plantar-wart other _____

Reproductive Pregnant _____ stage _____ PMS other _____

Respiratory breathing difficulty sinus problems allergies _____ asthma other _____

Other chemical sensitivity contagious disease _____ depression diabetes drug/alcohol eating disorder

food sensitivity aids hiv positive nicotine/caffeine implant/prosthesis contact lens cancer (additional page)

Surgeries, significant accidents or major injuries: *Please describe*

	Year

Lifestyle

Physical activities/exercise…frequency? _____

Do you smoke? Amount? _____ Alcohol? Amount? _____

What do you do to relax? _____

Do you sleep well? _____ Position? _____

Touch History

Have you experienced emotional, physical or sexual abuse? _____

Are there areas of your body that are touch sensitive? (Painful? Ticklish?) _____

The gluteal cleft, genitals and female breast are not uncovered or massaged. Are there any other areas you do

not want massaged? _____

Have you experienced massage / bodywork / energy work (please circle) before? _____ How recently? _____

What did you like best about your bodywork? _____ Least? _____

What are your reasons for receiving massage/bodywork now? _____

Are you allergic to any lotions or oils? _____

Consent

It is my choice to receive massage therapy, bodywork and/or energy work. I recognize that treatment is given for the wellbeing of body and mind. This includes stress reduction, relief from muscular tension, spasm and pain, increased circulation, energy flow. I agree to communicate with my therapist immediately should I feel uncomfortable with any modality or approach.

I understand that healing practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I understand that massage and bodywork are not substitutes for medical examination or diagnosis and that I must see a physician for those services.

If I have cancer or a chronic disease, I have previously consulted with my physician about massage and bodywork and I have informed my therapist of any suggested limitations and/or restrictions.

I have stated all medical conditions of which I am aware, and I will inform my therapist of any change in my health status.

Signature: _____ Date: _____