CLIENT INTAKE FORM

Client Contact Information

First Name

Last Name

Phone Number

Email

Date of Birth

Address

Emergency Contact:

Name: Phone Number:

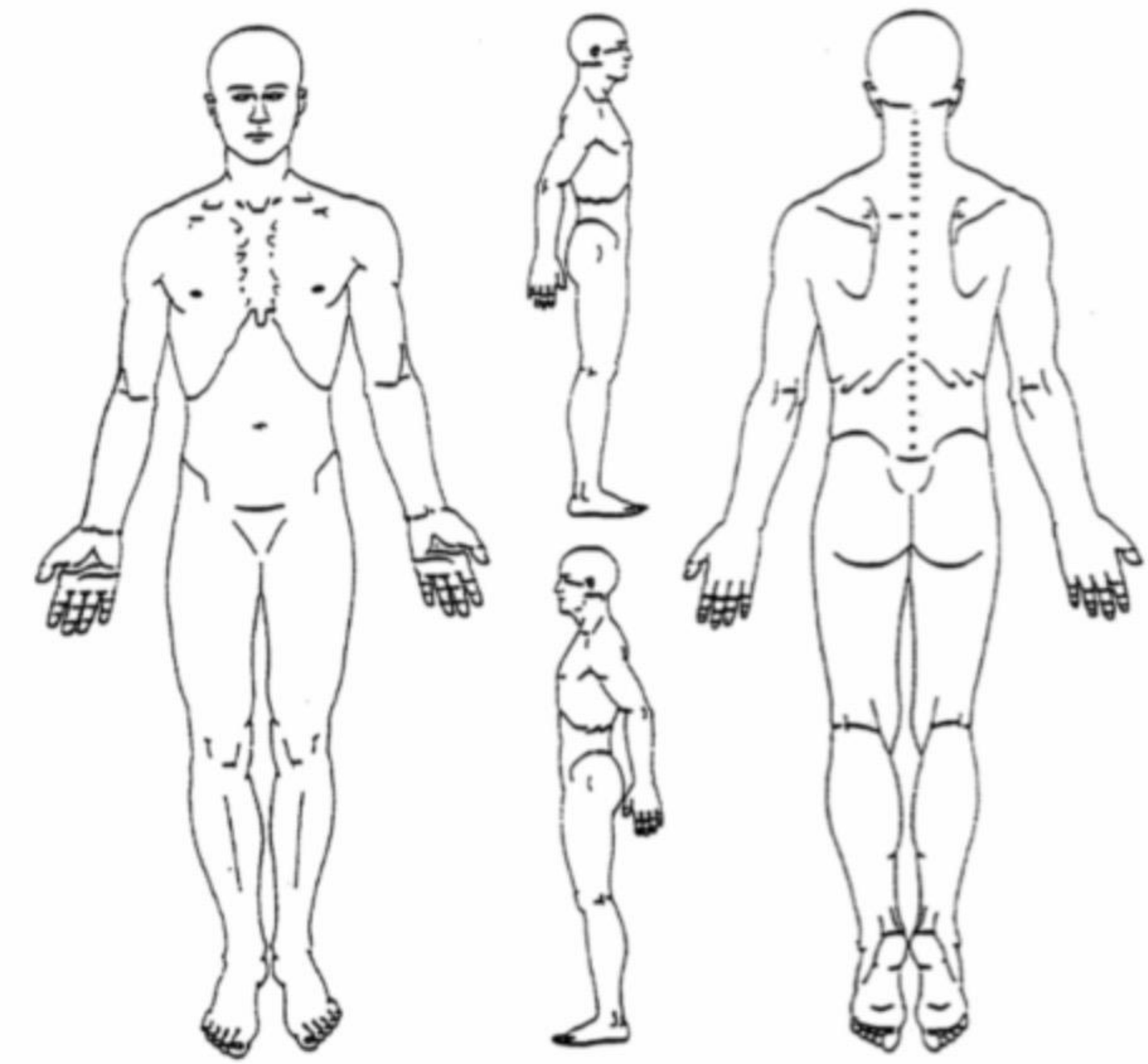
Doctor's Contact Information (optional)

Name: Phone Number:

How did you hear about us?

ISSUES TO ADDRESS

Mark area(s) of issues you would like to address, add description of sensation(s) i.e. tight, sharp pain, sore, bruising, dull ache, etc.



Cause of injury or concern

How long since first noticed

Treatment goals

Past treatments

RESPIRATORY

- [ ] Asthma
- [ ] Shortness of Breath
- [ ] Bronchitis
- [ ] Chronic Cough
- [ ] Emphysema

CARDIOVASCULAR

- [ ] Pacemaker
- [ ] Varicose Veins
- [ ] Cardiovascular Accident
- [ ] Congestive Heart Failure
- [ ] Low Blood Pressure
- [ ] Phlebitis
- [ ] Cerebral-vascular Accident
- [ ] Heart Attack
- [ ] Stroke
- [ ] Lymphedema
- [ ] Cold Feet
- [ ] Heart Disease
- [ ] Thrombosis/Embolism
- [ ] Myocardial Infraction

SKIN

- [ ] Bruise Easily
- [ ] Skin Irritations
- [ ] Hypersensitive Reaction
- [ ] Melanoma
- [ ] Skin Conditions

HEAD & NECK

- [ ] Ear Problems
- [ ] Hearing Loss
- [ ] Sinus Problems
- [ ] Vision Problems
- [ ] Vision Loss
- [ ] Migraines
- [ ] Headaches
- [ ] Jaw Pain (TMJD)

INFECTIOUS CONDITIONS

- [ ] Athlete's Foot
- [ ] Respiratory Conditions
- [ ] Hepatitis
- [ ] Skin Conditions
- [ ] HIV
- [ ] Herpes

REPRODUCTIVE

- [ ] Pregnancy
- [ ] Gynecological Issues

FAMILY HISTORY

- [ ] Cardiovascular Conditions
- [ ] Respiratory Conditions

NEUROLOGICAL

- [ ] Burning
- [ ] Numbness
- [ ] Tingling
- [ ] Stabbing Pain
- [ ] Cerebral Palsy
- [ ] Parkinsons
- [ ] Multiple Sclerosis
- [ ] Herniated Disc

MISCELLANEOUS

- [ ] Allergies
- [ ] Cancer
- [ ] Dizziness
- [ ] Hemophilia
- [ ] Mental Illness
- [ ] Surgical Pins or Wire
- [ ] Anaphylaxis
- [ ] Crohn's Disease
- [ ] Epilepsy
- [ ] Arthritis
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Artificial Joins/ Special Equipment
- [ ] Diabetes
- [ ] Fibromyalgia

- [ ] Loss of Sensation
- [ ] Osteoporosis
- [ ] Shingles
- [ ] Stress
- [ ] Insomnia
- [ ] Anxiety
- [ ] Depression
- [ ] Digestive Conditions
- [ ] Gout
- [ ] Lupus
- [ ] Other Diagnosed Diseases
- [ ] Medical Conditions

ALLERGIES AND OTHER CONDITIONS YOUR PROVIDER SHOULD KNOW OF

MEDICATIONS
Please, list any medications or drugs you are currently on

CLIENT WAIVER FORM

Please take a moment to read and initial the following information:

• I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

• If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

• I understand that the services offered today are not a substitute for medical care.

• I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

• I affirm that I have notified my therapist of all known medical conditions and injuries.

• I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

• I understand that massage is entirely therapeutic and non-sexual in nature.

• By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

SIGNATURE*

I have read the statement and agree to all the policies *

Date: MM/DD/YYYY