

Today's Date: _____

CLIENT INTAKE FORM

This questionnaire has been designed to assist your massage therapist in providing optimal therapeutic care and service. All information provided will be kept in the strictest confidence.

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____

Emergency Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name of primary health care practitioner _____

Medical conditions for which you are currently being treated _____

Referred by _____

When was your last therapeutic massage? _____

What benefits do you hope to gain through massage? _____

MEDICAL INFORMATION

Today's primary concern: _____

Level of discomfort: mild _____ moderate _____ severe _____

Duration: constant _____ intermittent _____

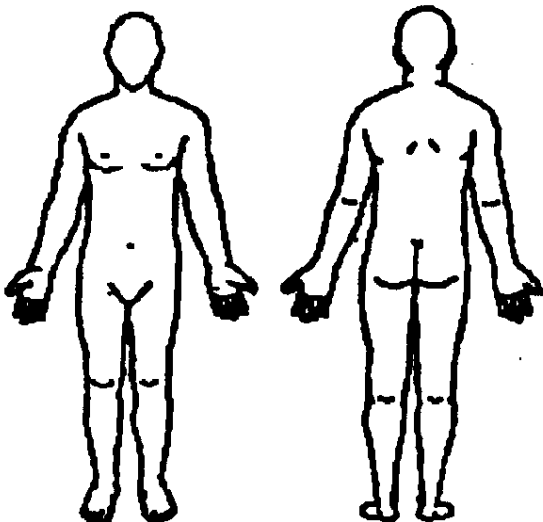
When did you first notice the discomfort? _____

What activities cause discomfort? _____

What helps relieve it? _____

Other areas of concern: _____

CIRCLE OR MARK AN "X" ON ALL AREAS OF THE BODY THAT YOU FEEL PAIN, TENDERNESS, NUMBNESS, TINGLING, OR OTHER DISCOMFORT.



Pre-Massage Pain Scale
0 _____ 5
No Pain _____ Severe Pain

Post-Massage Pain Scale
0 _____ 5
No Pain _____ Severe Pain

MEDICAL HISTORY

Please check all the following that apply to you:

- Heart Problems Blood Pressure Problems Skin Problems
- Spinal/Back/Neck Problems Digestive/Intestinal Problems Varicose Veins
- Immune Deficiency Diseases Sleep Problems Frequent Headaches
- Jaw Pain/Sinus/Dental Problems Hip or Leg Problems
- Mental/Emotional Stress Seizures/Epilepsy Diabetic
- Wear: Contacts Dentures Hearing Aid
- Have: Implants Prosthesis Pacemaker

Allergies _____

Other conditions or comments _____

Surgeries? Accidents? _____

Pregnant? Number of Weeks _____ Tendency to be: hot cold

Average Daily Intake of: Tobacco _____ Caffeine _____ Alcohol _____

Any areas of body sensitive to touch or therapist should avoid?

Your choice of exercise or stress-reducing activities:

Current medications, supplements or complementary therapies (such as chiropractic care):

INFORMED CONSENT

I understand that massage therapy is not a substitute for medical care and that any information provided by the therapist is for educational purposes only and is not diagnostic or prescriptive in nature.

Because a massage therapist must be aware of existing physical and mental conditions, I have stated all my known medical conditions and taken it upon myself to keep the massage therapist updated on my physical and mental health.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment. I understand that I will be charged for appointments not cancelled 24 hours in advance and all returned checks incur a fee of \$20.00.

SIGNATURE _____ *DATE* _____