MASSAGE: NEW CLIENT INTAKE

Health Information:	
Client Name:	Date:
Date of Birth:	Gender: M F
Address:	
Phone: Email:	
Referred by:	
Emergency contact: Phon	e:
Is this massage/bodywork medically necessary (is it for a medical condition, \Box Do you have a physician referral/prescription? Yes \Box No \Box	injury, surgery)? Yes □ No
Massage Information:	
Have you ever received professional massage/bodywork before? Yes □ No	☐ How recently?
What kind of pressure do you prefer? Light Medium Firm	
What are your goals/expected outcomes for receiving massage/bodywork?	
How do you feel today?	
EMOTIONALLY: PHYSICALLY:	
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/t	ingling, swelling, etc.):
Do these symptoms interfere with your activities of daily living (e.g., sleep, exerc Yes□ No□ Explain:	ise, work, childcare)?
List the medications you currently take:	
Are you wearing contacts? Yes No No No No	

Are you pregnant? Yes \(\subseteq \text{No} \subseteq \text{If yes: how far along: \(\subseteq \text{Long: } \)			
Have you had any injuries or surgeries in the past? Yes \square No \square If yes, please explain with dates as close as possible:			
Circle any of the	following health conditions that you currently have (If you are unsure, please ask):		
-blood clots	-infections -congestive heart failure -contagious diseases -pitted edema		
Please indicate o	conditions that you have or have had in the past. Explain in detail, including treatment received:		
Current Past	Numbness or tingling (area)		
Current Past	High/Low blood pressure		
Current Past	Stroke, heart attack		
Current Past	Varicose veins		
Current Past	Cancer (type and year)		
Current Past	Neurological (e.g. MS, Parkinson's, chronic pain)		
Current Past	Epilepsy, seizures		
Current Past	Headaches, Migraines (cause of?)		
Current Past	Digestive conditions (e.g. Crohn's, IBS)		
Current Past	Kidney disease, infection		
Current Past	Arthritis (rheumatoid, osteoarthritis) (area)		
Current Past	Osteoporosis, degenerative spine/disk		
Current Past	Scoliosis		
Current Past	Broken bones (area)		
Current Past	Allergies (seasonal, food, scents, etc)		
Current Past	Diabetes Insulin pump?		
Current Past	Endocrine/thyroid conditions		
Current Past	Depression, anxiety		
Consent for Tr	reatment: If I experience any pain or discomfort during this session, I will immediately inform the		
	at the pressure and/or strokes may be adjusted to my level of comfort. I further understand that		
•	ork should not be construed as a substitute for medical examination, diagnosis, or treatment and		
	a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of		
	e. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal		
	gnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the		
	uld be construed as such. Because massage/bodywork should not be performed under certain		
_	ons, I affirm that I have stated all my known medical conditions and answered all questions honestly.		
	e practitioner updated as to any changes in my medical profile and understand that there shall be		
_	practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive		
· ·	nces made by me will result in immediate termination of the session, and I will be liable for payment		
	appointment. Understanding all of this, I give my consent to receive care.		
Client Signature:	Date:		

Parent or Guardian Signature (in case of a minor):	Date: