CLIENT INTAKE AND MEDICAL HISTORY FORM

NAME_____ DATE_____

ADDRESS_____CITY_____STATE_____ ZIP_____

PREFERRED PHONE NUMBER_____ EMAIL_____

BIRTHDATE _____/_____/_____ OCCUPATION_____

EMERGENCY CONTACT_____ PHONE_____

HOW DID YOU HEAR ABOUT US? _____ ARE YOU REDEEMING A GIFT CARD / PACKAGE? _____

Please take a moment to carefully read the following information. If you have a specific medical condition or specific symptoms, Bodywork / Massage may be contraindicated. A referral from your Primary Care Provider may be required prior to any services being rendered.

HAVE YOU EVER RECEIVED THERAPEUTIC BODYWORK OR MASSAGE BEFORE? ☐ YES ☐ NO

IF YES, WHAT TYPE AND HOW LONG AGO? _____

WHAT IS YOUR PREFERRED LEVEL OF PRESSURE? (CIRCLE ALL THAT APPLY): **LIGHT - MEDIUM - FIRM - STRONG**

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS SESSION?_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST NAMES AND REASON/TREATMENT_____

DO YOU HAVE ALLERGIES? PLEASE SPECIFY: _____

PLEASE REVIEW AND CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CURRENT OR PAST HEALTH:

_____PREGNANCY - HOW MANY WEEKS? _____

_____BACK INJURIES/PAIN

_____NECK INJURIES/PAIN

_____NUMBNESS, TINGLING OR NERVE PROBLEMS

_____MUSCLE STRAIN/SPRAIN

_____HIGH BLOOD PRESSURE

_____STROKE

_____INSOMNIA

_____HEPATITIS

_____SURGERIES_____

_____TMJ SYNDROME

_____DISLOCATIONS/FRACTURES

_____HEADACHES

_____ARTHRITIS

_____HEART CONDITIONS

_____SKIN CONDITIONS: ECZEMA, WARTS, RASHES, FUNGUS…

_____DIGESTIVE DISCOMFORT

_____CANCER _____TYPE / YEAR?

_____AUTO-IMMUNE CONDITION

_____DIABETES

_____NAUSEA/FAINTING SPELLS

_____DEPRESSION

_____OTHER CONDITIONS_____

_____BRUISE EASILY

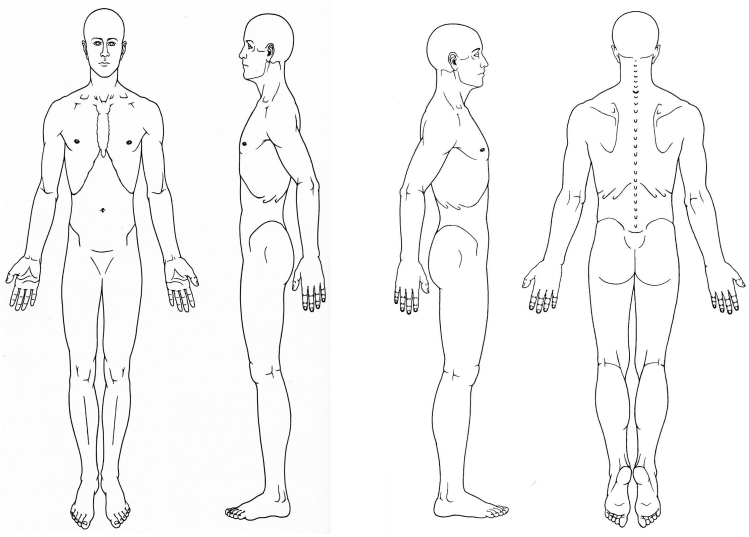
_____BLOOD CLOTS

_____SEIZURES

_____ANXIETY

USING THE DIAGRAM TO THE RIGHT:

1. PLEASE INDICATE WITH A **(O)** AREAS YOU WOULD LIKE ADDRESSED.



CONSENT FOR CARE

PLEASE READ THE FOLLOWING INFORMATION, CHECK (✔) YOU UNDERSTAND AND SIGN BELOW:

- ❑ I acknowledge that the therapeutic bodywork/massage services being provided are not a substitute for medical examination, diagnosis and treatment. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat physical illness.

- ❑ I understand that bodywork/massage is a therapeutic health aid and is non-sexual in nature. I am aware that any inappropriate behavior will result in an immediate termination of the session and/or future services.

- ❑ I have read the above information and completed this form to the best of my knowledge. Being that bodywork/massage should not be done under certain medical conditions I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to inform the therapist of any changes in my health and medical condition and that there shall be no liability on the therapist's part should I forget to do so.

- ❑ By signing this "Release" Form, I hereby release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

SIGNATURE_____ **DATE**_____

CONSENT TO TREATMENT OF MINOR (if you are 18 years and under):

By my signature below, I hereby authorize _____ to administer bodywork/massage therapy techniques to my child or dependent as they deem necessary.

SIGNATURE OF PARENT OR GUARDIAN_____ **DATE**_____

- OFFICE USE -

Staff Initial: _____ Location: LA | PT