Client Intake Form

Name: _____ Sex: o Male o Female

Address: _____

City:_____ State: _____Zip: _____

Daytime Phone #: _____Evening Phone #: _____

Date of Birth: _____Occupation_____

How did you hear of us?_____ Email _____

Emergency Contact Information

Marital status: o Single o Married / Gender: o Male o Female / Age of Others ir

Home:_____

Name of Spouse/Significant Other:_____ _____

In Case of Emergency, Please Notify (Name):_____

Telephone #: _____ Relationship: _____

Medical Care Information

Do you have a doctor's prescription for receiving massage? o No o Yes

Primary Doctor:_____

Doctor's Street Address: _____

City:_____State:_____Zip:_____

Telephone #: _____

Ok to contact Primary Provider? o No o Yes _____(please (initial if yes)

Current Activity Information

Do you experience professional massage/bodywork/energy medicine regularly? o No o Yes

(how often?what types of work?)_____

Do you exercise regularly? o No o Yes (if yes, how often) _____

Please list exercise activities_____

_____

Are you currently experiencing any major physical, emotional or psychological conditions o symptoms? If so, please describe)_____

_____

Do you have any unusual food cravings or sleep disturbances? If so, when they occur?

Do you have any difficulties with change of seasons? Which seasons?

What do you consider to be your most serious problem(s), if any? Please describe

Please list you current levels (1-10): pain_____ stress____ energy____ joy____ peace____

Health History Information

Please list any accidents, hospitalizations, surgeries, when they occurred, & treatment received

Do you have any chronic, ongoing pain or other lingering effects? If yes, please describe care/treatment you are currently receiving

Are you taking any prescribed drugs, supplements, or herbs? (If yes, please list them &why taken

Please list any allergies and/or medications & supplements to which you have sensitivity/reaction(s)

Check the following conditions that apply to you, past and present.

Musculoskeletal
o Headaches
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Strains/sprains
o Back, hip pain
oShoulder,neck,arm,hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Tendinitis
o Bursitis
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Cold sweats
o Swollen ankles
o Pressure sores
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Allergies
o Sinus problems
o Asthma
o High blood pressure
o Low blood pressure
o Lymphedema

Skin
o Rashes
o Allergies
o Athlete's Foot
o Warts
o Moles
o Acne
o Cosmetic surgery

Digestive
o Nervous stomach
o Indigestion
o Constipation
o Intestinal gas/bloating
o Diarrhea
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Colitis
o Adaptive aids
o Other:

Nervous System
o Numbness/tingling
o Twitching of face
o Fatigue
o Chronic pain
o Sleep disorders
o Ulcers
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Chronic Fatigue Syndrome
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury

Reproductive System
o Pregnancy:
  o Current
  o Previous
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Loss of appetite
o Forgetfulness
o Confusion
o Depression
o Difficulty concentrating
o Drugs_____
o Alcohol_____
o Nicotine_____
o Caffeine _____
o Hearing impaired
o Visually impaired
o Burning upon urination
o Bladder infection
o Eating disorder
o Diabetes
o Fibromyalgia
o Post/Polio Syndrome
o Cancer
o Infectious disease (please list)
_____
o Other congenital or acquired disabilities_____
o Metal in your Body? Where?
_____

II have stated all conditions that I am aware of and this information is true and accurate. understand that massage therapists and energy medicine practitioners do not diagnose disease o prescribe drugs and they are not a substitute for medical care. I agree to alert my practitioner o any physical or emotional changes as they occur. I also understand that a missed appointmen might incur charges that I must pay.

Client's/Guardian (if Under 18) Signature: _____ Date: _____