CLINIC CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Date: ____/____/____
Address: _____
City/State/Zip: _____ Occupation: _____
Phone (Home): _____ Phone (Cell): _____ Phone (Work) _____
Birthdate: ____/____/____ Height: _____ Weight: _____ Gender: M____ F____
EmailAddress: _____
Emergency Contact: _____ Phone: _____
Statement of Intoxicants: Please indicate by initialing below if you have consumed any intoxicating substance or non-prescribed drug prior to arriving for your bodywork session. Yes _____ No_____ If yes, please indicate substance consumed: _____

Have you ever received a professional massage? ☐ Yes ☐ No If Yes, Frequency/Type: _____
Date of last massage: _____ What results do you want from your massage? _____

Are you currently seeing a medical practitioner? Please explain if yes ☐ Yes ☐ No _____

List current medications, including aspirin, ibuprofen, herbs, supplements, etc. _____

List stress reduction and exercise activities (include frequency) _____

MEDICAL HISTORY (Include year and treatment received)

Allergies: _____
Surgeries: _____

Accidents/Injuries/Illnesses: _____

Are you wearing contacts? _____ Dentures? _____ Transdermal patches (nicotine) ____ IV Port? _____

Having a complete medical history is important for our assessment process and in the determination of your customized massage plan. In each of the following sections please mark the "past" and/or "current" box next to any of the items that apply to your health history.

MUSCULOSKELETAL

Past	Current		Past	Current	
___	___	bone or joint disease	___	___	low back, hip pain
___	___	tendonitis	___	___	neck, shoulder, arm pain
___	___	bursitis	___	___	headaches
___	___	broken/fractured bones	___	___	spasms/cramps
___	___	arthritis	___	___	jaw pain
___	___	sprains/strains	___	___	lupus
___	___	scoliosis	___	___	wrist/hand pain
___	___	disc disease/ herniated disc	___	___	leg/foot pain
___	___	other (please explain): _____			

CIRCULATORY

Past	Current	
___	___	heart/vessel conditions
___	___	varicose veins
___	___	high blood pressure
___	___	low blood pressure
___	___	blood clots
___	___	lymphedema
___	___	other: _____

URINARY

Past	Current	
___	___	cystitis
___	___	kidney disease
___	___	urinary tract infections
___	___	other: _____

NERVOUS SYSTEM

Past	Current	
___	___	numbness/tingling
___	___	chronic pain
___	___	herpes/shingles
___	___	fatigue
___	___	sleep disorders
___	___	other: _____

DIGESTIVE

Past	Current	
___	___	chronic/problematic constipation
___	___	crohn's disease
___	___	diverticulitis
___	___	irritable bowel syndrome/colitis
___	___	reflux
___	___	other: _____

RESPIRATORY

Past	Current	
___	___	breathing difficulty
___	___	sinus problems
___	___	allergies
___	___	other: _____

REPRODUCTIVE

Past	Current	
___	___	pregnancy, # wks_____
___	___	endometriosis
___	___	severe bloating/cramps
___	___	menopausal symptoms
___	___	painful/irregular/absent periods
___	___	other: _____

SKIN

Past	Current	
___	___	rashes/eczema/psoriasis
___	___	athlete's foot
___	___	warts
___	___	allergies
___	___	other: _____

OTHER

Past	Current	
___	___	headaches/migraines
___	___	cancer/tumors
___	___	thyroid issues
___	___	diabetes
___	___	eating disorders
___	___	depression/anxiety
___	___	drug/alcohol/nicotine addiction
___	___	hearing loss
___	___	other: _____

SIGNATURE _____ DATE _____