

| | |
|---|---|
| **Phone** | (706) 552-0774 |
| **Email** | info@athenscenterformt.com |
| **Clinic** | 520 Gaines School Road<br>Athens, Georgia 30605 |


| | | | |
|---|---|---|---|
| **Date** | month | day | year |

# CLIENT INTAKE FORM



## GENERAL DETAILS & CONTACT INFORMATION

| | |
|---|---|
| **First Name** | |
| **Last Name** | |

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| ***How did you hear about us?*** |
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| | | |
|---|---|---|
| **Mailing Address** | | |
| **City & State** | | postal code |

| | |
|---|---|
| **Birthday** | mm / dd / yyyy |
| **Age** | |

| | |
|---|---|
| **Home Phone** | |
| **Cell Phone** | |

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|---|
| **Email Address** |
| |

| | |
|---|---|
| **Occupation** | |
| **Business or Employer** | |

| | |
|---|---|
| **Gender** | |
| Male ☐ | Female ☐ |

## GENERAL PRACTITIONER INFORMATION

| | |
|---|---|
| **Name of GP** | |

| | |
|---|---|
| **Phone** | |

## MEDICAL HISTORY

| | | |
|---|---|---|
| **Have you had previous care from a...** | ☐ **Massage Therapist** | ☐ **Chiropractor** |
| | ☐ **Physical Therapist** | ☐ **Acupuncturist** |

| | | | |
|---|---|---|---|
| **Name of practitioner** | | **Phone** | |
| **Name of practitioner** | | **Phone** | |
| **Reason for visit...** | | **Date of visit...** | mm / dd / yyyy |
| **List all surgeries (with dates)** | | | |
| **List all bone fractures (with dates)** | | | |

| | | | |
|---|---|---|---|
| **How often do you exercise:** | | **What is your overall stress level?** ☐ **Low** ☐ **Med.** ☐ **High** | |
| **What types of exercise:** | | **Reasons for stress:** | |

## FOR WOMEN ONLY (MEN, PROCEED TO THE NEXT PAGE)

| | | | |
|---|---|---|---|
| **Are you pregnant?** ☐ **Yes** ☐ **No** ☐ **Maybe** | | **Do you have children?** ☐ **Yes** ☐ **No** | |
| **Due date:** | mm / dd / yyyy | **If yes, by:** | ☐ **vaginal delivery** ☐ **caesarean delivery** |
| **First day of last period:** | mm / dd / yyyy | If you are currently menstruating, please leave your panties on during the massage session | |

Pain and discomfort can be traced back to many different origins. To obtain a complete picture of your overall health, please complete the following form. If you have had or are currently experiencing any of the following symptoms/conditions listed below, please check the corresponding box.

## General
- ☐ Insomnia
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain

## Head
- ☐ Headache
- ☐ Dizziness
- ☐ Head Trauma
- ☐ Fainting
- ☐ Blacking out

## Ears
- ☐ Ringing/Tinnitus
- ☐ Impaired Hearing
- ☐ Earaches

## Nose
- ☐ Sinus Problems
- ☐ Nosebleeds

## Lungs
- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Persistent Cough
- ☐ Asthma
- ☐ Emphysema
- ☐ C.O.P.D

## Vascular
- ☐ Angina
- ☐ Murmurs
- ☐ Heart Disease
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Varicose Veins
- ☐ Low Blood Pressure
- ☐ High Blood Pressure

## Gastro-Intestinal
- ☐ Bloating/Gas
- ☐ G.E.R.D
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hernia(s)

## Urinary
- ☐ Incontinence
- ☐ Frequent Infections
- ☐ Kidney Stones

## Neurological
- ☐ Seizures/Epilepsy
- ☐ Stroke(s)
- ☐ Tingling Sensation
- ☐ Numbness
- ☐ Muscle Weakness
- ☐ Paralysis

## Muscle & Bone
- ☐ Joint Pain
- ☐ Swollen Joints
- ☐ Stiffness
- ☐ Muscle Ache
- ☐ Bone Pain
- ☐ Fractures
- ☐ Dislocations
- ☐ Sprains/Strains

## Skin
- ☐ Rash
- ☐ Itching Hives
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema
- ☐ Skin Sensitivities

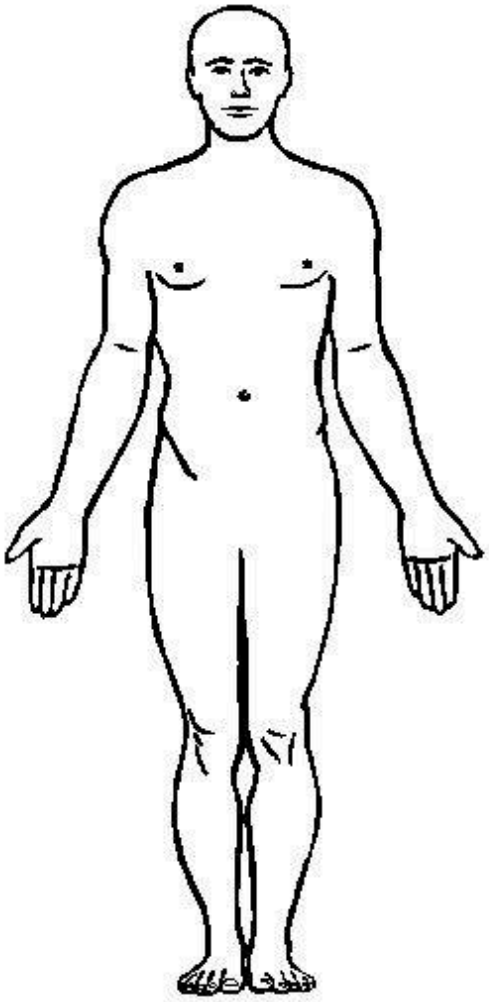
## Endocrine
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hormone Therapy
- ☐ Thyroid Problems
- ☐ Heat/Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Sweating
- ☐ Night Sweats

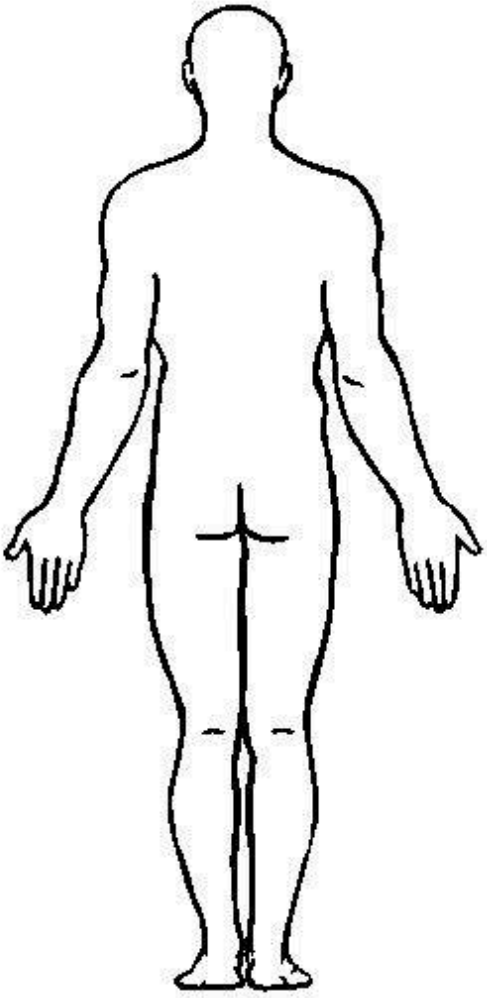
## Emotional
- ☐ Depression
- ☐ Anxiety/Nervousness
- ☐ Mood Swings
- ☐ Tension
- ☐ Phobias
- ☐ Alcohol/Drug Abuse

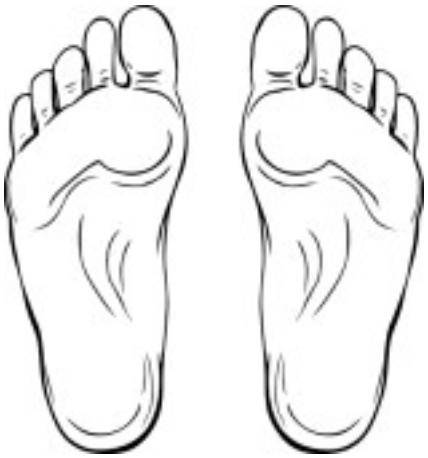
## Conditions
- ☐ AIDS/HIV
- ☐ Heart Condition
- ☐ Rheumatic Arthritis
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Tumor/Growths
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Lou Gehrig's (ALS)
- ☐ Gout
- ☐ Migraines
- ☐ Anemia
- ☐ Fibromyalgia
- ☐ Hepatitis
- ☐ Contagious Diseases

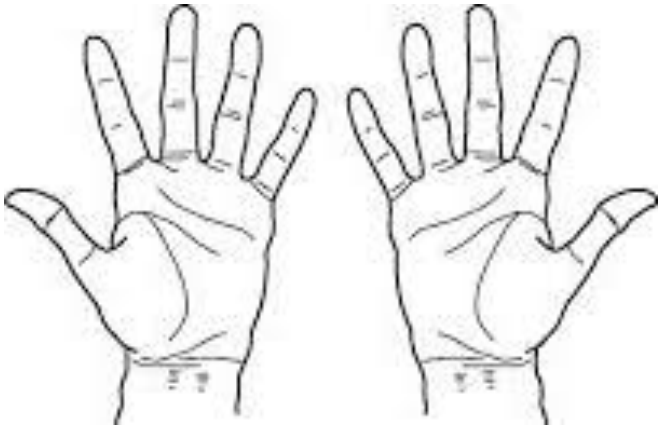
| Please list all known allergies: | |
|---|---|

**Please circle your areas of discomfort on the diagram below.**









**Please read the following carefully and enquire if you have any questions or concerns. You must sign and date this form.**

## Massage Therapy Consent Form

I understand that the massage(s) I receive at Athens Center for Massage Therapy is provided for the basic purpose of relaxation and relief of muscular tension. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any physical or mental ailments that I am aware of.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile and understand that there shall be no liability on the massage therapists part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be held liable for full payment of the scheduled appointment.

I also understand that Athens Center for Massage Therapy reserves the right to refuse to perform massage on anyone whom they deem to have a condition for which massage is contraindicated.

By signing this consent form, I hereby state that I have read and fully understand all of the information detailed in it and that I agree to all of its terms and conditions.

| | |
|---|---|
| Client Signature | |
| Client Name (please print) | |
| Date Signed | mm / dd / yyyy |