

Casey Broome, LMT
CONFIDENTIAL CLIENT INTAKE INFORMATION AND HEALTH HISTORY

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone :(h) _____ (c) _____ Date of Birth: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referred By: _____

How did you hear about me? Current Client? ____ Family/Friend? ____ Sign? ____ Flyer? ____ My Website? ____ Other? ____

Is this your first professional massage? ____ If no, how frequent do you get a massage? _____

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? ____ If yes, location(s): _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel you have recovered from these events? ____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? ____ Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? ____ Please explain: _____

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what

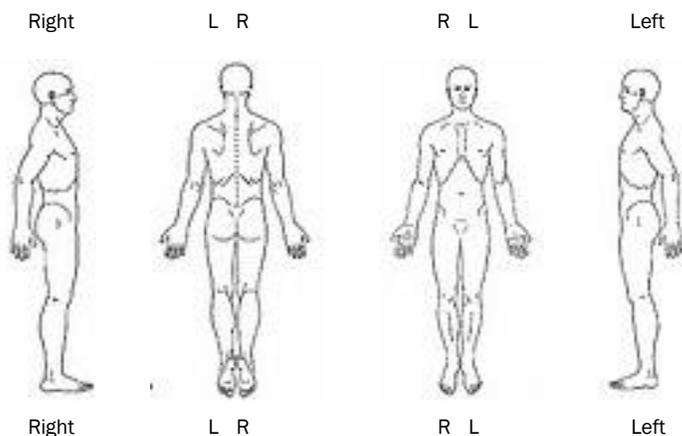
Medication is used to treat): _____

Are you currently under the care of a physician? ____ Whom? _____

Please list reason(s): _____

Are there any health concerns you wish to discuss today? ____ If yes, please describe: _____

Please indicate where you experience pain on the drawing below



Are you currently experiencing any of the following conditions? (Yes/No)

_____ Flu/Cold _____ Inflammation _____ Fever _____ Infection _____ Contagious Disease

Please mark any of the following conditions below that currently affect you (with a C) or that you have experienced in the last 5 years (with a P).

MUSCULOSKELETAL

- ___ Fibromyalgia
- ___ Spasms/Cramps
- ___ Sprains/Strains
- ___ Osteoporosis
- ___ Postural Deviations
- ___ Gout
- ___ Osteoarthritis/Rheumatoid Arthritis
- ___ TMJ Dysfunction
- ___ Cysts
- ___ Bursitis
- ___ Plantar Fasciitis
- ___ Torticollis
- ___ Whiplash Syndrome
- ___ Carpal Tunnel Syndrome
- ___ Sciatica
- ___ Thoracic Outlet Syndrome
- ___ Headache
- ___ Leg Pain
- ___ Arm Pain/Shoulder Pain
- ___ Low Back Pain
- ___ Mid Back Pain
- ___ Hip Pain
- ___ Other

RESPIRATORY

- ___ Pneumonia
- ___ Sinusitis
- ___ Asthma
- ___ Trouble Breathing
- ___ Dizziness
- ___ Other

CIRCULATORY

- ___ Anemia
- ___ Hemophilia
- ___ Hypertension
- ___ Low Blood Pressure
- ___ Raynaud's Disease
- ___ Varicose Veins
- ___ Heart Condition
- ___ Blood Clots/Phlebitis
- ___ Diabetes
- ___ Other
- ___ Ulcers
- ___ Irritable Bowel Syndrome
- ___ Colitis
- ___ Gallstones
- ___ Hepatitis
- ___ Crohn's Disease
- ___ Diarrhea
- ___ Gas/Bloating
- ___ Indigestion
- ___ Other

SKIN

- ___ Fungal Infections - Acne
- ___ Impetigo
- ___ Dermatitis/Eczema
- ___ Psoriasis
- ___ Open Wound or Sore
- ___ Rashes
- ___ Warts/Moles
- ___ Athletes Foot
- ___ Allergies
- ___ Other

NERVOUS SYSTEM

- ___ ALS
- ___ Multiple Sclerosis
- ___ Parkinson's Disease
- ___ Bell's Palsy
- ___ Neuritis
- ___ Spinal Cord Injury
- ___ Stroke
- ___ Trigeminal Neuralgia
- ___ Seizure Disorders
- ___ Numbness/Tingling/Twitching
- ___ Other
- ___ Tendonitis

OTHER

- ___ Insomnia
- ___ Sleep Apnea
- ___ Anxiety/Panic Attacks
- ___ PMS
- ___ Physical/Emotional Abuse
- ___ Grief Process
- ___ Cancer
- ___ Substance Abuse
- ___ Pregnancy
- ___ Chronic Fatigue
- ___ HIV/AIDS
- ___ Lupus
- ___ Kidney Disease
- ___ Bladder Infection
- ___ Postoperative Situation
- ___ Edema
- ___ Other

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I understand this is a Non-Sexual massage. I understand that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for full payment of the scheduled appointment. I also understand that that cancelled or missed appointments with out 24 hour notice (medical excluded) will be charged in full for the price of the missed session.

Signature: _____ Date: _____