

CLINIC CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Date: ____/____/____

Address: _____

City/State/Zip: _____

Phone (Home): _____ Phone (Cell): _____ Phone (Work): _____

Birthdate: ____/____/____ Height: _____ Weight: _____ Gender: M _____ F _____

Email/Address: _____

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

SIGNATURE _____

DATE _____

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: _____