

Client Intake Form

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Personal Information

Date of visit

First name

Last name

Birthday

Gender

Email

Phone

Occupation

Referred by

Address

City

State

Zip code

Physician name

Physician phone

Emergency contact

Emergency phone

Reason for Visit

How would you rate your general health?

- ☐ Poor ☐ Fair
☐ Good ☐ Excellent

Have you ever had a professional massage?

- ☐ No
☐ Yes Last time?

Describe injuries, concerns, or issues to address + causes and dates of occurrences

Empathy Health

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Describe any treatment you've received for these particular issues

Describe your treatment goals

Health History

Cardiovascular

- | | | |
|--|--------------------------------------|---|
| <input type="radio"/> Congestive heart failure | <input type="radio"/> Embolism | <input type="radio"/> Heart attack |
| <input type="radio"/> Heart disease | <input type="radio"/> Hemophilia | <input type="radio"/> High blood pressure |
| <input type="radio"/> Low blood pressure | <input type="radio"/> Pacemaker | <input type="radio"/> Phlebitis |
| <input type="radio"/> Poor circulation | <input type="radio"/> Stroke | <input type="radio"/> Thrombosis |
| <input type="radio"/> Varicose veins | <input type="radio"/> Family history | |

Head & Neck

- | | | |
|------------------------------------|---------------------------------------|---------------------------------|
| <input type="radio"/> Dizziness | <input type="radio"/> Ear problems | <input type="radio"/> Headaches |
| <input type="radio"/> Hearing loss | <input type="radio"/> Jaw pain (TMJ) | <input type="radio"/> Migraines |
| <input type="radio"/> Vision loss | <input type="radio"/> Vision problems | |

Musculoskeletal

- | | | |
|------------------------------------|---|----------------------------------|
| <input type="radio"/> Arthritis | <input type="radio"/> Artificial joint | <input type="radio"/> Bursitis |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Surgical pin/wire | <input type="radio"/> Tendonitis |

Neurological

- | | | |
|---|--|---|
| <input type="radio"/> Epilepsy | <input type="radio"/> Multiple sclerosis | <input type="radio"/> Numbness/tingling |
| <input type="radio"/> Sensory loss/change | <input type="radio"/> Sciatica | <input type="radio"/> Seizures |

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Respiratory

- | | | |
|---------------------------------|---|--------------------------------------|
| <input type="radio"/> Asthma | <input type="radio"/> Bronchitis | <input type="radio"/> Chronic cough |
| <input type="radio"/> Emphysema | <input type="radio"/> Shortness of breath | <input type="radio"/> Sinusitis |
| <input type="radio"/> Smoker | <input type="radio"/> Tuberculosis | <input type="radio"/> Family history |

Reproductive

- | | | |
|-----------------------------------|--|--------------------------------|
| <input type="radio"/> Given birth | <input type="radio"/> Gynecological problems | <input type="radio"/> Pregnant |
|-----------------------------------|--|--------------------------------|

Skin

- | | | |
|--|---------------------------------------|---------------------------------------|
| <input type="radio"/> Bruise easily | <input type="radio"/> Skin conditions | <input type="radio"/> Skin infections |
| <input type="radio"/> Skin irritations | | |

Miscellaneous

- | | | |
|--------------------------------|--|------------------------------------|
| <input type="radio"/> Anxiety | <input type="radio"/> Cancer | <input type="radio"/> Depression |
| <input type="radio"/> Diabetes | <input type="radio"/> Digestive conditions | <input type="radio"/> Fibromyalgia |
| <input type="radio"/> HIV/AIDS | <input type="radio"/> Stress | <input type="radio"/> Other |
-

Waiver

Please read and sign:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that today's services are not a substitute for medical care and that my therapist is not qualified to diagnose, prescribe, or treat physical/mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition and that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I waive and release my therapist from any liability, past, present, and future, relating to massage therapy and bodywork.

Signature _____

Date _____

Empathy Health