client intake form

personal information

name

address

city state zip

home phone cell phone

work phone

email

occupation

marital status

referred by

emergency contact emergency contact phone

physician's name physician's phone

massage experience

Have you had a professional massage? Yes No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?

How long have you been receiving massage?

Frequency of massage?

What are your goals for treatment?

current health

Do you exercise regularly and/or participate in any sports? Yes No

If yes, what type of exercise/sport?

Do you perform any repetitive movement in your work, sport or hobby? Yes No

If yes, describe

Do you experience stress in work, family, or other aspects of your life? Yes No

If yes, describe

Are you experiencing tension, stiffness, discomfort or pain? Yes No

If yes, please describe

Have you recently had an injury, surgery or have any areas of inflammation? Yes No

If yes, please describe

Do you have sensitive skin? Yes No

Do you have any allergies? Yes No

Please list:

List any medications you are currently taking:

health history

Musculoskeletal
__ Bone or joint disease
__ Tendonitis/Bursitis
__ Arthritis/Gout
__ Jaw Pain (TMJ)
__ Lupus
__ Spinal Problems
__ Migraines/Headaches
__ Osteoporosis

Psychological
__ Anxiety/Stress
__ Depression

Circulatory
__ Heart Conditions
__ Phlebitis/Varicose Veins
__ Blood Clots
__ High/Low Blood Pressure
__ Lymphedema
__ Thrombosis/Embolism

Skin
__ Allergies
__ Rashes
__ Cosmetic Surgery
__ Athlete's Foot
__ Herpes/Cold Sores

Nervous System
__ Shingles
__ Numbness/Tingling
__ Pinched Nerve
__ Chronic Pain
__ Paralysis
__ Multiple Sclerosis
__ Parkinson's Disease

Respiratory
__ Asthma/Breathing Difficulty
__ Emphysema
__ Nasal Allergies
__ Sinus Problems

(Continued on back)

client intake form (side 2)

health history (continued)

Digestive
__ Irritable Bowel Syndrome
__ Bladder/Kidney Ailment
__ Colitis
__ Crohn's Disease
__ Ulcers

Reproductive
__ Pregnant, stage? _____
__ Ovarian/Menstrual Problems
__ Prostrate

Other
__ Cancer/Tumors
__ Diabetes
__ Contact Lenses
__ Hearing Aids
__ Dentures

Use space below to explain checked conditions or note any other medical conditions(s) not listed:

_____

_____

_____

_____

_____

client agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any change in my health status.

_____
initial

contract for care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care program and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

_____
initial

release of medical records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purpose of processing my claims.

_____ _____
signature date