New Client Massage Intake Form

Personal Information

Name _____ Email: _____

Phone # _____ Occupation _____

Emergency Contact _____ Relationship _____ contact phone # _____

Current & Past Health History

Do you practice a consistent fitness program**? ___ yes _____no**

If yes, what kind of program? _____

Any repetitive movement in your work, sports, hobby? _____

Do you sit for long periods at work, driving, etc

_____

Have you recently been ill or, recently had an injury, surgery or, areas of inflammation __(yes)____(no)

List ALL history of injuries, surgeries, sprains, breaks, etc…

_____

_____

_____

Musculoskeletal ***Respiratory***

____ *Bone or joint disease* ____*Arthritis/Gout* ____*Emphysema*

___*Tendonitis/Bursitis* ____*Jaw Pain (TMJ)* ____*Breathing difficulty Asthma*

____*Spinal Problems, specify*_____ ____ *Osteoporosis* _____*Sinus Problems*

____*Lupus*

Circulatory ***Nervous System*** ***Psychological***

___*Heart Condition* ____*Shingles* ____*Anxiety/Stress*

___*Varicose Veins* ____*Numbness/Tingling* ____*Depression*

___*Blood Clots* ____*Pinched Nerve*

___*High/Low Blood Pressure* ____*Chronic Pain*

___*Lymphedema* ____*Paralysis*

___*Thrombosis/Embolism* ____*Multiple Sclerosis*

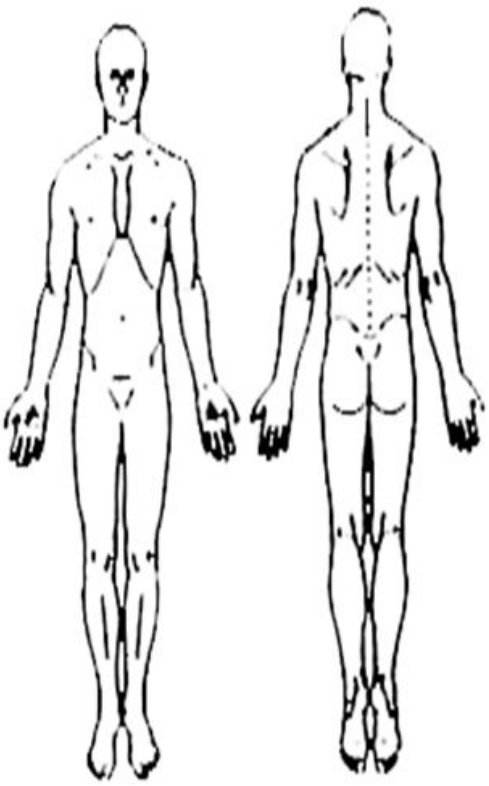
Skin ***Digestive*** ***Other***

____*Allergies, specify:* ___*Irritable Bowel Syndrome* __*Cancer/Tumors*

_____ ___*Bladder/Kidney Ailment* __*Diabetes*

_____*Cosmetic Surgery, specify:* ___*Colitis* ____*Migraines/Headaches*

_____ ___*Crohn's Disease* ___*Ulcers*



Therapist Assessment:

Client Name:

_____

Date:

_____

Reason for Client visit:

_____

Objective clinical observations derived from:

- *Interview:*
- *Palpation:*
  - *Visual Exam:*
  - *Posture Assessment:*

Treatment Provided:

- *Treatment used:*
- *Client's response to treatment:*

Cell phone #