WARMTH LLC.
Wellness, Athletic, Relaxation, Massage Therapies for Health

CLIENT INTAKE FORM

About You

Date: _____
Name: _____ Sex: ( ) Male ( ) Female
Address: _____
City: _____ State: _____ Zip: _____
Daytime Phone #: _____ Evening Phone #: _____
Date of Birth: _____ E-Mail Address _____
Marital status: ( ) Single ( ) Married ( ) Divorced ( ) Widow
Name of Spouse/Significant Other: _____
Are you or have you ever been in the US Military? ( ) Y ( ) N Branch: _____

In Case of Emergency

Name: _____ Telephone #: _____
Relationship: _____

Marketing

Who referred you to this office? ( ) Previous Client ( ) Ad ( ) Other: _____
Name or Promo Code: _____
May we email you with promotional material? ( ) Yes ( ) No Please initial here if yes. _____

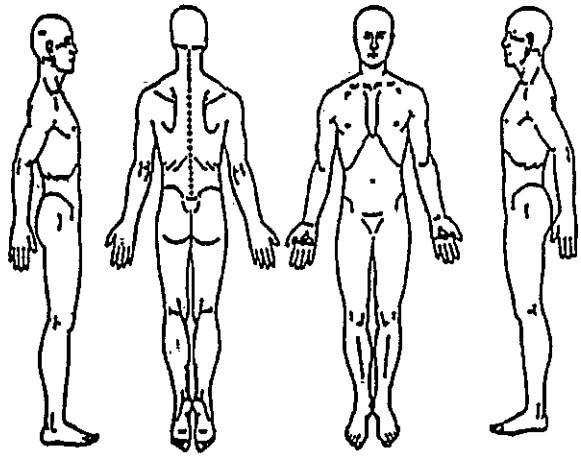
Daily Activities

Occupation: _____ Employer: _____
Describe exercise activities you do (include frequency): _____
_____

Health History

Have you had a professional massage before? ( ) Yes ( ) No If "yes" when was your last massage? _____
If yes how often do you receive massage therapy? ( ) 2+/month ( ) Monthly ( ) 2-6 / Year ( ) Yearly
Reason(s) for your visit today: _____
Do you have any expectations or goals in mind for massage therapy? ( ) Yes ( ) No
Please explain: _____
List any medications (including aspirin) and nutritional supplements you are taking: _____
_____
_____
List any allergies you have: _____
_____
Are you currently under medical supervision? ( ) Yes ( ) No
If "yes" please explain: _____
_____
_____

Use the chart to indicate areas of discomfort or areas to work on.>



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HEALTH HISTORY

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal
- o Headaches
- o Joint stiffness/swelling
- o Spasms/cramps
- o Broken/fractured bones
- o Strains/sprains
- o Back, hip pain
- o Shoulder, neck, arm, hand pain
- o Leg, foot pain
- o Chest, ribs, abdominal pain
- o Bone/joint replacement
- o Jaw pain/TMJ
- o Tendonitis
- o Bursitis
- o Arthritis
- o Osteoporosis
- o Scoliosis
- o Bone or joint disease
- o Other: _____

Circulatory and Respiratory
- o Dizziness
- o Shortness of breath
- o Fainting
- o Cold feet or hands
- o Cold sweats
- o Swollen ankles
- o Pressure sores
- o Varicose veins
- o Blood clots
- o Stroke
- o Heart condition
- o Sinus problems
- o Asthma
- o High blood pressure
- o Low blood pressure
- o Lymphedema
- o Other: _____

Skin
- o Rashes
- o Allergies
- o Athlete's Foot
- o Warts
- o Moles
- o Acne
- o Cosmetic surgery
- o Other: _____

Digestive
- o Nervous stomach
- o Indigestion
- o Constipation
- o Intestinal gas/bloating
- o Diarrhea
- o Irritable bowel syndrome
- o Crohn's Disease
- o Colitis
- o Other: _____

Nervous System
- o Numbness/tingling
- o Twitching of face
- o Fatigue
- o Chronic pain
- o Sleep disorders
- o Ulcers
- o Paralysis
- o Herpes/shingles
- o Cerebral Palsy
- o Epilepsy
- o Chronic Fatigue Syndrome
- o Multiple Sclerosis
- o Muscular Dystrophy
- o Parkinson's disease
- o Spinal cord injury
- o Other: _____

Reproductive System
- o Pregnancy:
  - o Current
  - o Previous
- o PMS
- o Menopause
- o Pelvic Inflammatory Disease
- o Endometriosis
- o Hysterectomy
- o Fertility concerns
- o Prostate problems

Other
- o Loss of appetite
- o Forgetfulness
- o Confusion
- o Depression
- o Difficulty concentrating
- o Alcohol use _____
- o Nicotine use _____
- o Caffeine use _____
- o Hearing impaired
- o Visually impaired
- o Burning upon urination
- o Bladder infection
- o Eating disorder
- o Diabetes
- o Fibromyalgia
- o Cancer
- o Infectious disease (please list)

_____

- o Other congenital or acquired disabilities (please list) _____

_____

- o Surgeries _____
- o Other: _____

Please list any additional comments regarding your health and well-being: _____

_____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____