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Intake and Consent Form

This Intake and Consent Form has been given to you to provide valuable information to assist in your massage and bodywork session. While sharing most information in this form is voluntary, you must fill out the contact information, as well as sign the consent at the end of this form, for us to work with you.

All information we obtain about you, whether written or shared verbally during session, and whether from you directly or another source, will be held in the utmost confidentiality.

We will never share your information, medical or otherwise, without your express written consent and direction, unless otherwise required by law.

While providing personal and medical information about you is entirely voluntary, without this information you may impair the progress of your sessions and potentially create risks to your health.

If you have any questions about how to complete this form, how we use your information, or what your rights are regarding your information, please ask your therapist immediately before signing below.

Client Name: _____

Date: _____



NEW CLIENT INTAKE & CONSENT FORM

Today's Date: _____

ABOUT YOU		
Name		
Email: May we add you to our subscriber list to get email updates, newsletters, and special offers? ____ Yes, please ---or--- No thank you, not at this time ____		
Address	City/State	Zip
Your occupation	Date of birth	

CONTACT INFO		
Mobile Phone	Home Phone	Work Phone
Is it ok to leave a message at mobile number? ____ Yes ____ No	Is it ok to leave a message at home number? ____ Yes ____ No	Is it ok to leave a message at work number? ____ Yes ____ No
Emergency contact name and telephone number		
How would you like to be notified of your appointments? Circle all that apply		
	Telephone	Email Text
How did you hear about us?		

MESSAGE INFO	
Have you ever received professional massage/bodywork before? ____ Yes ____ No If yes, how recently?	
What type of massage/bodywork do you prefer?	
What type of pressure do you prefer? ____ Light ____ Medium ____ Firm	
Is today's massage/bodywork medically necessary (i.e., is it for a medical condition, injury, surgery?) ____ Yes ____ No	
Do you have a physician referral/prescription? ____ Yes ____ No	
What are your goals/expected outcomes for receiving massage/bodywork on this visit?	
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):	
What areas do you specifically want addressed during your massage?	Are there any areas you specifically want avoided during your massage? If yes, please list here.



HEALTH INFORMATION — If more room is needed for any answer, please continue your answer in the extra space on page 3

<p>Are you wearing contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing hearing aids? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing a hairpiece? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks? _____ Due date: _____ Are you currently trying to become pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Please list any medications you currently take:</p>
<p>Have you had any injuries, accidents, or surgeries in the past that may influence today's treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:</p> <p>Please answer honestly, as massage may not be indicated for the conditions listed below. Do you currently have the following health conditions (if you are unsure, please ask):</p> <p>Blood clots <input type="checkbox"/> Yes <input type="checkbox"/> No Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Contagious diseases <input type="checkbox"/> Yes <input type="checkbox"/> No Pitting edema <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Please list any allergies and/or skin sensitivities:</p> <p>Our products may contain nut oils. Are you allergic to nuts or nut products? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list the types of nuts:</p>
<p>Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:</p> <p>Current Past Muscle or joint pain Current Past Muscle or joint stiffness Current Past Numbness or tingling Current Past Swelling Current Past Bruise easily Current Past Sensitive to touch/pressure Current Past High/low blood pressure Current Past Stroke, heart attack Current Past Varicose veins Current Past Shortness of breath, asthma Current Past Cancer Current Past Neurological (e.g. MS, Parkinson's) Current Past Epilepsy, seizures Current Past Headaches, migraines Current Past Dizziness, ringing in the ears Current Past Gas, bloating, constipation Current Past GI conditions (e.g. Crohn's, IBS) Current Past Kidney disease, infection Current Past Arthritis (rheumatoid, osteoarthritis) Current Past Osteoporosis/osteopenia Current Past Scoliosis Current Past Broken bones Current Past Diabetes Current Past Endocrine/thyroid conditions Current Past Depression/anxiety Current Past Memory loss, confusion</p>	<p>Please use this space to explain any conditions and to provide additional comments regarding your health history. Use back side of this form if necessary.</p> <hr/> <p>Good Fair Poor Ability to relax? Good Fair Poor Sleep patterns? Average no. of hours' sleep per night? _____</p> <p>Yes No Do you sleep with cell phone near bed?</p> <p>Yes No Do you see natural daylight in your workplace?</p> <p>Yes No Do you work at a computer? _____ hours</p> <p>Yes No Do you eat regular meals? Yes No Do you eat in a hurry?</p> <p>Yes No Do you smoke? Yes No Do you drink alcohol?</p> <p>Regular Occasional Irregular Exercise?</p>
<p>How do you feel today?</p>	



OTHER COMMENTS/INFORMATION

Is there any other information you would like to provide that has not been covered on this form? If you have an issue that you do not wish to state on this form, please discuss it with your therapist.

On a scale of 0 to 10, please rate the following (zero being none to ten being the worst):

Your current overall stress level: _____

Your current overall pain level: _____

Your limitations in function: _____

CONSENT FOR TREATMENT

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should seek a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments or diagnosis, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this I give my consent to receive care.

Client signature

Date

Parent or Guardian Signature (in case of a minor)

✓ _____
