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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 address:		
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 did you hear about us?		

MASSAGE 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 aggravates your symptoms?	What relieves your symptoms?
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.
How do you feel today?	

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

Are you wearing contacts? ___ Yes ___ No
Are you wearing dentures? ___ Yes ___ No
Are you wearing hearing aids? ___ Yes ___ No
Are you wearing a hairpiece? ___ Yes ___ No

Are you currently pregnant? ___ Yes ___ No If yes, how many weeks? _____ Due date: _____
Are you currently trying to become pregnant?
___ Yes ___ No

Please list any medications you currently take:

Past surgical history:

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):

Blood clots ___ Yes ___ No
Congestive heart failure ___ Yes ___ No
Infections ___ Yes ___ No
Contagious diseases ___ Yes ___ No
Pitting edema ___ Yes ___ No

Please list any allergies and/or skin sensitivities:

Our products may contain nut oils. Are you allergic to nuts or nut products? ___ Yes ___ No

If yes, please list the types of nuts:

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

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
Current Past Dermatologic/Skin conditions

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.

_____

Good Fair Poor Ability to relax?
Good Fair Poor Sleep patterns? Average no. of hours' sleep per night? _____

Yes No Do you sleep with cell phone near bed?

Yes No Do you see natural daylight in your workplace?
Yes No Do you work at a computer? _____ hours

Yes No Do you eat regular meals?
Yes No Do you eat in a hurry?

Yes No Do you smoke?
Yes No Do you drink alcohol?

Regular Occasional Irregular Exercise?

OTHER COMMENTS/INFORMATION

Do you have any history of accidents or injuries? If yes, please provide details

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
Parent or Guardian Signature (in case of a minor)

✓_____

Date

_____