b.ZEN Massage

client intake form

client signature

date of initial visit

personal information

name | date of birth

address

city | state | zip

home phone | cell phone

work phone | ext.

email

occupation

employer

employer address

marital status | if married, spouses name

referred by

emergency contact name (relationship) | emergency contact phone

physician's name | physician's phone

massage experience

Have you had a professional massage before? ❒ Yes ❒ No

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

How long have you been receiving massage therapy?

Frequency of massages?

What are your goals for treatment?

current health

Reason for initial visit

Height & weight

Do you exercise regularly and/or participate in any sports? ❒ Y ❒ N

If yes, what kind of exercise/sports?

Do you perform any repetitive movement in your work, sports or hobby? ❒ Y ❒ N

If yes, describe

Do you sit for long hours at a workstation, computer or driving? ❒ Y ❒ N

If yes, describe

Do you experience stress in your work, family, or other aspect of your life? ❒ Y ❒ N

If yes, describe

Are you experiencing tension, stiffness, discomfort or pain? ❒ Y ❒ N

If yes, describe

Have you recently had an injury, surgery, or areas of inflammation? ❒ Y ❒ N

If yes, describe

Do you have sensitive skin? ❒ Y ❒ N

Do you have any allergies to oils, lotions or ointments? ❒ Y ❒ N

If yes, please explain

List any medications you are currently taking

List any known allergies

health history

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

Circulatory
___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory
___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify:
___ Sinus Problems

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

Reproductive
___ Pregnant, stage
___ Ovarian/Menstrual Problems
___ Prostate

Skin
___ Allergies, specify:
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

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

Psychological
___ Anxiety/Stress Syndrome
___ Depression

Other
___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above :