

Intentional Healing, LLC

Massage/Bodywork Client Intake Form

The following information will be used to help plan safe and effective massage sessions.
This information is confidential so please answer the questions to the best of your knowledge.

Personal Information

Name: _____ Date of initial visit: ___/___/_____
Preferred Name: _____ Preferred Pronoun: she/her he/him they/them other: _____
Address: _____ City: _____ Zip: _____
Phone: _____ (mobile/work/home) Email: _____
Occupation: _____ Date of Birth: ___/___/_____
Emergency contact: _____ Phone: _____

Massage & Bodywork

Have you had a professional massage before? Yes No
If yes, what type(s) of massage have you had Swedish Structural Deep Tissue Thai Other _____
How often do you receive massage therapy? _____ Date of last session: ___/___/_____
Explain your experience / outcome: _____
Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain _____
Please indicate your goals for treatment: _____

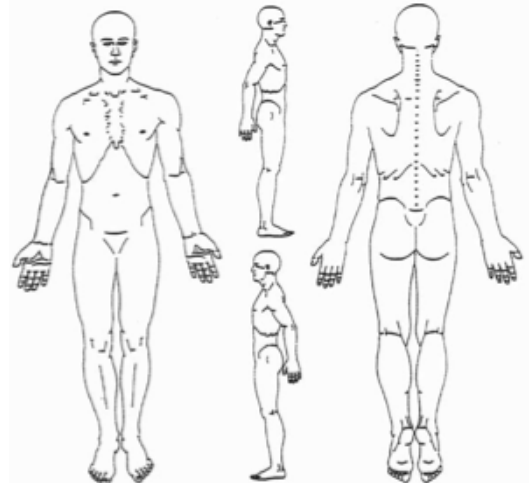
Current Health

Do you exercise regularly and/or participate in any sports? Yes No
If yes, what kind of exercise/sports? How frequently? _____
Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____
Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please explain _____
Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please explain _____
Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health? _____

Please mark with an "X" on the lines below if you are experiencing any of the following:

No Pain	Pain
0 _____	10 _____
No Tension	Tension
0 _____	10 _____
No Stiffness	Stiffness
0 _____	10 _____
No Anxiety	Anxiety
0 _____	10 _____
No Insomnia	Insomnia
0 _____	10 _____
No Irritability	Irritability
0 _____	10 _____
Can do anything	Can't Do Anything
0 _____	10 _____

Please indicate on the body below the area where you are currently experiencing pain, tension and/or stiffness with the following marks: Pain X Tension 0 Stiffness S



Health History

Please check any current and/or previous conditions that apply to you:

Musculoskeletal

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

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, trimester _____
- Ovarian/Menstrual Problems
- Prostate

Skin

- Allergies, specify _____
- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold Sores

Digestive

- Irritable Bowel Disease
- Bladder/Kidney Ailment
- Colitis
- Crohn's Disease
- Ulcers
- Nausea

Psychological

- Anxiety/Stress Syndrome
- Depression
- PTSD

Other

- Cancer, specify _____
- Diabetes, type _____
- Stroke
- Aneurysm
- Seizures
- Inflammation/Swelling
- Communicable Disease
- Compromised Immune
- Cold/Flu/Fever
- COVID-19
- Easy Bruising
- Contact Lenses
- Dentures
- Hearing Aids
- Alcohol Use, frequency _____
- Drug Use, frequency _____
- Tobacco Use, frequency _____
- _____

Please explain any of the health conditions indicated above: (has it been diagnosed by a health care provider?) _____

Please provide information on the following (including type, approximate date and treatment):

Surgeries: _____

Major Illnesses: _____

Injuries/Accidents: _____

Please list any medication (including prescription, herbs, drugs, homeopathic remedies, vitamins, or supplements) you are currently taking (and their side effects) as it may affect the work that is performed: _____

Do you have any questions, concerns additional medical conditions, or information I should know about? _____

Physician: _____ Phone: _____

May I have permission to contact your health care provider(s) about your medical history? This is often helpful in determining the best and/or safest course of action. Please initial: Yes _____ No _____

Informed Consent

I verify that all the above information provided is correct and current to the best of my knowledge. I understand that I will be receiving massage/bodywork. I understand the practitioner is currently a licensed/certified massage therapist in the states of Washington and Oregon. That the practitioner has received training in the modalities she offers. I understand these sessions may include bodyreading, range of motion testing, massage, manual therapy and movement therapy. I understand that the practitioner may not diagnose or prescribe any medications and that this should not take the place of medical advice and/or treatment. I understand that either the practitioner or I can stop the session if either experience discomfort inappropriate for the situation. Discomfort may include, but is not limited to: physical pain, sexually suggestive behavior, personal remarks or requests. I expressly waive, release, discharge, and hold harmless Intentional Healing, LLC and the practitioner of any and all liability claims and demands, including attorney fees and costs, as a result of my participation in any activity of any type at Intentional Healing, LLC. I understand that all cancellations require 24-hour notice, or the full session fee may be charged or billed to the insurance company (at the discretion of the practitioner). If I have any illness, injury or surgery, I will contact Intentional Healing, LLC as soon as possible so a decision can be made about rescheduling. I verify I have read and agree to policies.

Signature: _____ Date: _____

Signature of parent or legal guardian (if client is a minor): _____