Intentional Healing, LLC

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

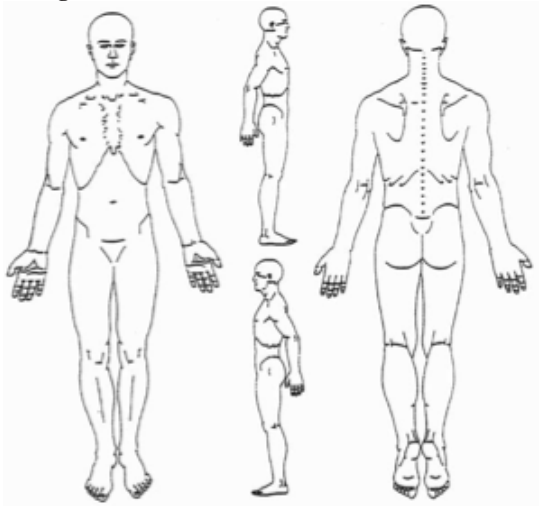
No Anxiety — Anxiety
0 ——— 10

No Insomnia — Insomnia
0 ——— 10

No Irritability — Irritability
0 ——— 10

Can Do Everything — 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
- ❑ Drug/Alcohol 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 California and Oregon. That the practitioner has received training in the modalities she offers. If our session involves structural integration for the purpose of balancing and aligning the physical body so it is supported by gravity and moves with greater ease and freedom, I understand these sessions may include bodyreading, massage, manual therapy and movement therapy. I understand that the practitioner may not diagnose or treat injuries or diseases or prescribe 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 or alter the treatment plan at any time if either experience discomfort inappropriate for the situation. Discomfort may include (but 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 (at the discretion of the practitioner). If I have any illness, injury or surgery, I will contact Intentional Healing, LLC so a decision can be made about rescheduling.

Signature: _____ Date: _____

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