CONFIDENTIAL CLIENT INTAKE FORM & INFORMED CONSENT

Name:_____ Date:____/____/____

Address:_____

City/State/Zip:_____ Occupation:_____

Phone (Home): _____ Cell:_____ Work:_____

Birthdate:____/____/____ Gender: ☐ M ☐ F

Email Address:_____

Emergency Contact:_____ Phone:_____

STATEMENT OF INTOXICANTS: Please indicate by initialing below if you have consumed any non-prescribed drug or have consumed any intoxicating substance prior to arriving for your bodywork session. YES ☐ NO☐

Are you currently seeing a medical practitioner? ☐ No ☐ If Yes, please explain_____

_____

List any current medications, including aspirin, ibuprofen, herbs, supplements, etc. _____

_____

List stress reduction and exercise activities (include frequency)_____

_____

MEDICAL HISTORY (include year and treatment received)

Allergies:_____

Surgeries (In the past 3 years or any surgery that is still affecting you today) _____

_____

Accidents/Injuries/Major Illnesses:_____

_____

Do you wear contacts? ☐ Dentures? ☐ Transdermal patches (nicotine)? ☐ IV Port? ☐

MUSCULOSKELETAL

Past	**Current**		**Past**	**Current**	
☐	☐	bone or joint disease	☐	☐	low back, hip pain
☐	☐	tendonitis	☐	☐	neck, shoulder, arm pain
☐	☐	bursitis	☐	☐	jaw pain
☐	☐	broken/fractured bones	☐	☐	wrist / hand pain
☐	☐	sprains/strains	☐	☐	leg / foot pain
☐	☐	Lupus	☐	☐	other:_____

CIRCULATORY

Past	Current	
☐	☐	heart/vessel condition
☐	☐	varicose veins
☐	☐	high blood pressure
☐	☐	low blood pressure
☐	☐	blood clots
☐	☐	lymphedema
☐	☐	other:_____

URINARY

Past	Current	
☐	☐	cystitis
☐	☐	kidney disease
☐	☐	urinary tract infections
☐	☐	other:_____

NERVOUS SYSTEM

Past	Current	
☐	☐	numbness / tingling
☐	☐	chronic pain
☐	☐	fatigue / sleep disorder
☐	☐	other:_____

OTHER

Past	Current	
☐	☐	headaches / migraines
☐	☐	thyroid issues
☐	☐	diabetes; neuropathy? ☐YES ☐NO
☐	☐	cancer / tumor

Any lymphnodes removed? ☐ YES ☐ NO

☐	☐	other:_____

RESPIRATORY

Past	Current	
☐	☐	breathing difficulty
☐	☐	sinus problems
☐	☐	other:_____

_____

REPRODUCTIVE

Past	Current	
☐	☐	pregnancy
☐	☐	endometriosis
☐	☐	severe bloating/cramps
☐	☐	menopausal symptoms
☐	☐	painful/irregular/absent periods
☐	☐	other:_____

SKIN

Past	Current	
☐	☐	rashes / eczema / psoriasis
☐	☐	athlete's foot
☐	☐	warts
☐	☐	other:_____

DIGESTIVE

Past	Current	
☐	☐	chronic / problematic constipation
☐	☐	irritable bowel syndrome
☐	☐	crohn's disease
☐	☐	diverticulitis / colitis
☐	☐	reflux / heartburn

I understand that massage therapy is being given for the well-being of my body and mind. This includes stress reduction, enhanced relaxation, relief from muscle tension, increased range of motion, improved circulation and to offer a positive experience of touch. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

_____I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will update the massage therapist of any changes in my health status.

_____ _____

Client Signature Date