

Today's Date: _____

CLIENT INTAKE FORM

Name: _____ Telephone: () _____ DOB _____

Address: _____ City: _____ Zip: _____

E-Mail: _____ May I contact you? _____ How did you hear about me? _____

Physician: _____ Telephone: () _____

Occupation: _____ Height: _____ Weight: _____

Are you basically in good health? YES or NO Has there been any change to your health in the past year? YES or NO
If so, please explain: _____

Current physical activities _____

Areas of emotional or physical stress _____

Prior Massage/Bodywork experience _____

Massage/Bodywork likes and dislikes:
Relaxation _____ Deep Tissue(NMT) _____ Reflexology _____ Myofascial Release _____ Trigger Point _____

What would you like the outcome of this session to be? _____

Other methods of treatment _____

Current Health Condition(s): circle all that apply

- | | | | |
|----------------------------------|--------------------------------|--|--|
| <i>Acid Reflux</i> | <i>Fever</i> | <i>Recent Trauma</i> | <i>4. Have you had any operations? _____</i> |
| <i>Allergies</i> | <i>Fibromyalgia</i> | <i>Scars</i> | _____ |
| <i>Anemia</i> | <i>Headaches</i> | <i>Sciatica</i> | <i>5. What were your occupations? _____</i> |
| <i>Arthritis</i> | <i>Heart Disease</i> | <i>Seizures</i> | _____ |
| <i>Asthma</i> | <i>Heartburn</i> | <i>TMJ</i> | <i>6. When was the first time you had the pain and what happened? _____</i> |
| <i>Athletes Foot</i> | <i>Herniated Disc</i> | <i>Tumors</i> | _____ |
| <i>Back or Neck Injury</i> | <i>High Blood Pressure</i> | <i>Ticklish</i> | <i>7. Medications? _____</i> |
| <i>Bruises</i> | <i>HIV</i> | <i>Ulcers</i> | _____ |
| <i>Cancer</i> | <i>Inflammation</i> | <i>Varicose Veins</i> | <i>Please use the back of this form should you need more space to answer the above questions. Thank you very much for the honor of choosing me to be your partner in health.</i> |
| <i>Carpal Tunnel</i> | <i>Insomnia</i> | <i>Other _____</i> | _____ |
| <i>Child Birth (Women – How)</i> | <i>Menopausal (Women)</i> | _____ | _____ |
| <i>Claustrophobia</i> | <i>Migraines</i> | <i>1. Where do you hurt? _____</i> | _____ |
| <i>Cold/Flu</i> | <i>Multiple Sclerosis</i> | _____ | _____ |
| <i>Constipation</i> | <i>Muscle Cramps</i> | <i>2. What were your sports in school? _____</i> | _____ |
| <i>Contact Lenses</i> | <i>Muscle Pull</i> | _____ | _____ |
| <i>Contagious Disease</i> | <i>Muscle Spasms</i> | <i>3. Have you had or been in any accidents? _____</i> | _____ |
| <i>Cough</i> | <i>Nausea</i> | _____ | _____ |
| <i>Cramps</i> | <i>Numbness & Tingling</i> | _____ | _____ |
| <i>Diabetes</i> | <i>Osteoporosis</i> | _____ | _____ |
| <i>Decreased ROM</i> | <i>Paralysis</i> | _____ | _____ |
| <i>Edema</i> | <i>PMS (Women)</i> | _____ | _____ |
| <i>Fainting Spells</i> | <i>Pregnancy (How?)</i> | _____ | _____ |
| | <i>Recent Surgery</i> | _____ | _____ |

I understand that massage therapy involves neither diagnosis nor treatment of any condition as it is not a substitute for medical care. I understand that I am responsible for providing medical information to my massage therapist. All information before or during sessions will remain confidential. Draping will be used at all times unless I request optional clothing; neither my breasts (female) nor genital areas will be massaged. If I am uncomfortable for any reason I may request to end the session and the session will be ended. Barring an emergency, I understand that 24 hour cancellation is required or the session fee will be paid in full.

Client Signature: _____ Date: _____
Christine Fox, NCTMB _____ Date: _____