customized bodywork & wellness

new client intake information form

Name_____ Date:_____ /_____ / _____

DOB: _____ /_____ / _____ Address: _____

City: _____ State: _____ ZIP: _____

Cell: _____ Work: _____ Home: _____

Email: _____ Physician: _____

Emergency Contact: _____ Phone: _____

Your Occupation: _____ Referred By: _____

Height: _____ ft _____in Weight: _____ lbs Are you a smoker? (Check) _____YES _____NO

What are your goals for this treatment? __ Relaxation __ Stress Relief __ Pain Relief __ Other:_____

Where are you feeling pain or discomfort? _____

Physicians you have seen for this discomfort: _____

Medical Diagnosis: _____

At my work, I mostly do:____Phone ____Computer ____Lifting ____Sitting ____Standing ____Driving

When was your last professional massage treatment? _____

What kind of pressure do you prefer? _____Light _____Medium _____Firm _____Deep Tissue

How often do you exercise? _____Daily _____Weekly _____3-6 times, week _____1-3 times per week

My exercises are usually: _____ Less than 30 Minutes _____ 30-60 minutes _____ More than 60 minutes

What type of exercise or flexibility do you do? _____

Please circle any of the following that apply to your condition currently, or during the past year. Massage Therapy may be contraindicated unless prescribed because of some medical conditions.

Muscle spasms in neck
Tightness in shoulder muscle
Pain in shoulder(s)
Pins and needles in hands/feet
Headaches
Whiplash
Dizziness
Sciatica
Numbness
Grating in neck
Hernia
Pinched nerve in back

Broken bones
Injuries
Allergies
Pregnancy
Limited range of motion
Constipation
Bladder trouble
Kidney trouble
Prostate problems
Pain in legs and feet
Chest pain
Swollen ankles
Blood clots/phlebitis

Low/high blood pressure
Cold feet or cold hands
Diabetes
Metal Implants or screws
Bruise easily
Back pain
Have on contact lenses
Contagious/infectious disease
Medications
Cancer
Varicose veins

Swollen/painful joints
Skin disorders
Ulcers
Fractures
Bruising
Difficulty breathing
TB
Herniated disc
Pacemaker
Epilepsy or seizures
Frozen shoulder
Wearing dentures

Other: _____

Please read the following, and sign below:

I understand that the massage therapy that I receive is provided for the purpose of relaxation and relief of muscular tension. Discomfort and pain can occur with massage therapy treatments. I agree to immediately inform the massage therapist should I experience any pain or discomfort during this session, or future sessions, so that the pressure and/or stroked may be adjusted to my level of comfort. I take full responsibility for any discomfort suffered. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose or prescribe treatment for any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such. I affirm that I have stated all my known conditions and answered all questions honestly. I understand that massage therapy should not be performed when certain medical conditions exist, such as (but not limited to) cancer, without physician approval. Therefore, I agree to keep the practitioner informed of my current medical condition.

I agree to give at least 24 hours notice to cancel an appointment. Should I fail to give this proper notice I agree to pay the full cost of the time booked.

Client Signature: _____ Date: _____ / _____ / _____

Consent to Treatment of Minor: *By my signature below, I hereby authorize the massage therapist to administer massage therapy to my child or dependent, as they deem necessary.*

_____ *Date:* _____ / _____ / _____

Signature of Parent or Guardian

_____

Printed Name of Parent or Guardian

Please color in any area of discomfort: