Client Intake Form
Intentional Healing

Personal Information

Name_____ Phone (Day)_____Phone (Eve)_____

Address_____

City/State/Zip_____

Email_____ Date of Birth_____ Occupation_____

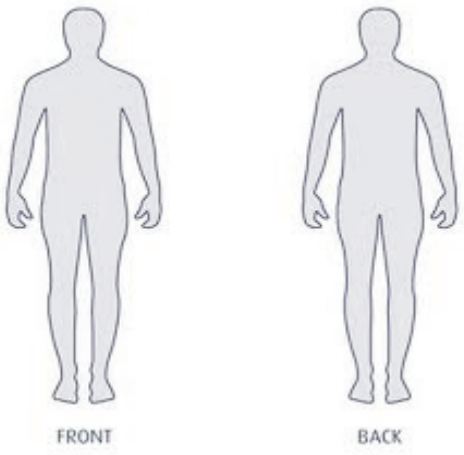
Emergency Contact_____ Phone_____

How did you hear about us? _____

The following information will be used to help plan safe and effective massage sessions. We want to make your appointment as pleasant and comfortable as possible. Please answer the questions to the best of your knowledge. If you have questions at anytime regarding your visit, please let us know.

1. Have you had a professional massage before? yes no
   If yes, how often do you receive massage therapy?_____
2. Do you have any difficulty lying on your front, back, or side? yes no
   If yes, please explain_____
3. Do you have any allergies to oils, lotions, or ointments? yes no
   If yes, please explain_____
4. Do you have sensitive skin? yes no
5. Are you wearing contact lenses? yes no Dentures? yes no Hearing Aid? yes no
6. Do you sit for long hours at a workstation, computer, or driving? yes no
   If yes, please describe_____
7. Do you perform any repetitive movement in your work, sports, or hobby? yes no
   If yes, please describe_____
8. 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?
   ( )Muscle tension ( )Anxiety ( )Insomnia ( )Irritability ( )Other_____
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? yes no
   If yes, please identify _____
10. Do you have any particular goals in mind for this massage session? yes no
    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session.



Medical History

In order to plan a massage session that is safe and effective, we need some general information about your medical history.

11. Are you currently under medical supervision? yes no
    If yes, please explain_____

12. Do you see a chiropractor? yes no
    If yes, how often _____

13. Are you currently taking any medications? yes no
    If yes, please list and what they are used for _____

14. Do you have any chronic bodily discomfort? yes no
    If yes, please describe_____

15. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins/phlebitis
( ) artery hardening
( ) neck pain
( ) mid back pain
( ) low back pain
( ) multiple sclerosis
( ) scoliosis
( ) hemophilia
( ) stroke

( ) tendonitis
( ) deep vein thrombosis/blood clots
( ) joint disorder
( ) rheumatoid arthritis
( ) osteoarthritis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation where?_____
( ) decreased range of motion where?_____
( ) fibromyalgia
( ) TMJ/jaw problems
( ) carpal tunnel syndrome
( ) tennis elbow
( ) digestive problems
( ) HIV, hepatitis, etc.
( ) numbing/tingling
( ) colitis/digestive problems
( ) pregnancy If yes, how many months?_____
Are you high risk?_____
( ) respiratory problems? what _____

16. Is there anything else about your health history that you think would be useful for your massage therapist to know?
_____

*Draping will be used during the session- only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the session or have informed written consent.

I,_____, (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be misconstrued as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be misconstrued as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

****I understand that there is a <u>cancellation/no show policy</u> at Intentional Healing. Cancellations must be made 24 hours PRIOR to the appointment time without being charged, otherwise payment in full is expected.**
****I understand that Intentional Healing periodically sends or emails promotions. Check here ___ if you do NOT want to receive any mail.**

Signature of client_____ Date_____

Signature of Massage Therapist_____ Date_____