Client Intake Form

Name: _____ Date of Birth: _____

Address: _____

City: State: Zip:

Phone #: _____cell/home__ May I text you? Yes_____ No_____

Email address: _____(please print)

Occupation: _____ Employer: _____

Primary Physician: _____

City/State:_____Phone #: _____

Permission to Consult with Primary Provider if needed? o No o Yes _____ (please initial if yes)

In Case of Emergency, Please Notify: _____ Telephone #: _____

Relationship: _____

Health History

Check the following conditions that apply to you, past and present. Please add your comments on the back to clarify the condition. Use the back of page if needed.

Do you have or have you ever had:		**Do you take medications?**
_____Cancer	_____Pregnant now?	_____Anti-inflammatories
_____chemo	_____Arthritis	_____Steroids
_____radiation	_____Allergies	_____Blood thinners
_____Lymphedema	_____Headaches	_____Water pill
_____Surgery	_____Pain	_____Cholesterol meds
_____Broken bones	_____chronic?	_____Heart medications
_____Replacement parts ☺	_____Rashes	_____Thyroid medication
_____hip	_____Digestion issues	_____Chemo pill
_____knee	_____Swelling	_____Opioids
_____breasts	_____Heart conditions	_____Pain medication
_____pins/screws/plates	_____High blood pressure	_____Allergy medication
_____cadaver bone/tendon	_____Auto accident	_____**Topical medications**
_____organ	_____Scars	Location_____
_____Varicose veins	_____Blood clots	_____Other
_____Neuropathy	_____Diabetes	**List any diagnosis given by your Doctor:**
_____tingling	_____insulin used?	
_____numbness	_____ Sports injury	
_____ TMJ disorder	_____ Other	

Please list any additional comments regarding your health and well-being (continue on back):

_____

_____

_____

Please initial each statement & sign below.

_____ I have completed this form to the best of my knowledge.
_____ I will inform the healthcare provider of any changes in my status.
_____ I understand that massage is designed to be a health aid & is in no way to take the place of a doctor's care.
_____ I will let the therapist know if I experience discomfort, so the therapist may adjust to my needs.
_____ I have read & signed the Policy Notification.
_____Appointments rescheduled or canceled within 24 hours of appointment will be subjected to a $25.00 cancelation fee. Chronic rescheduling/canceling of same appointment (3 or more times) will result in a dismissal as a client.

Client's Signature: _____ Date: _____