Client Intake Form

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The information you provide here will be used to customize your session to your needs, and exclude any techniques that may be medically unsuitable. Your privacy is protected.

Name _____Date of Birth_____M ( ) F ( )

Address _____City/State/Zip_____

Phone(H) _____(C) _____(W) _____

Email _____Occupation_____

M.D._____Chiropractor_____
Emergency Contact Name and Phone

_____
Current Medications (include OTCs, Supplements and Herbs) and WHY

_____

_____
Have you had a professional massage before: Y ( ) N ( )

Allergies? _____

Goals for this session? _____

Currently under medical supervision? Explain _____
Please checkmark any condition/symptom listed below that applies to you, current or past:

Musculoskeletal
__Artificial Joint
__Baker's Cyst
__Bursitis
__Fibromyalgia or CFS
__Muscular Dystrophy
__Osteoarthritis
__Osteporosis
__Plantar Fascitis
__Rheumatoid Arthritis
__Tendonitis
__Whiplash
__Other _____

Nervous System
__Alzheimer's
__Herpes Zoster/Shingles
__MS
__Parkinson's
__Peripheral Neuropathy
__Seizures
__Spinal Cord Injury
__Numbness
__Other_____

Circulatory System
__Atherosclerosis
__Deep Vein Thrombosis (DVT)
__Heart Attack
__High Blood Pressure
__Leukemia
__Low Blood Pressure
__Stroke
__Varicose Veins
__Other_____

Digestive System
__Crohns
__IBS
__Ulcers
__Ulcerative Colitis
__Other_____

Lymph/Immune System
__Allergic Reactions
__Chronic Fatigue
__HIV/AIDS
__Lupus
__Lymphoma
__Other_____

Respiratory System
__Asthma
__Chronic Bronchitis
__Sinusitis
__Other_____

Integumentary System (Skin)
__Athlete's Foot
__Boils
__Burns
__Cold Sore/Herpes
__Dermatitis
__Impetigo
__Open Sores/Wounds
__Psoriasis
__Rashes
__Warts
__Other_____

Miscellaneous
__Cancer
__Depression
__Diabetes
__Easy Bruising
__Headaches
__Migraines
__Numbness
__Pregnant
__Other_____

Please list any accidents or surgeries to date

_____

_____

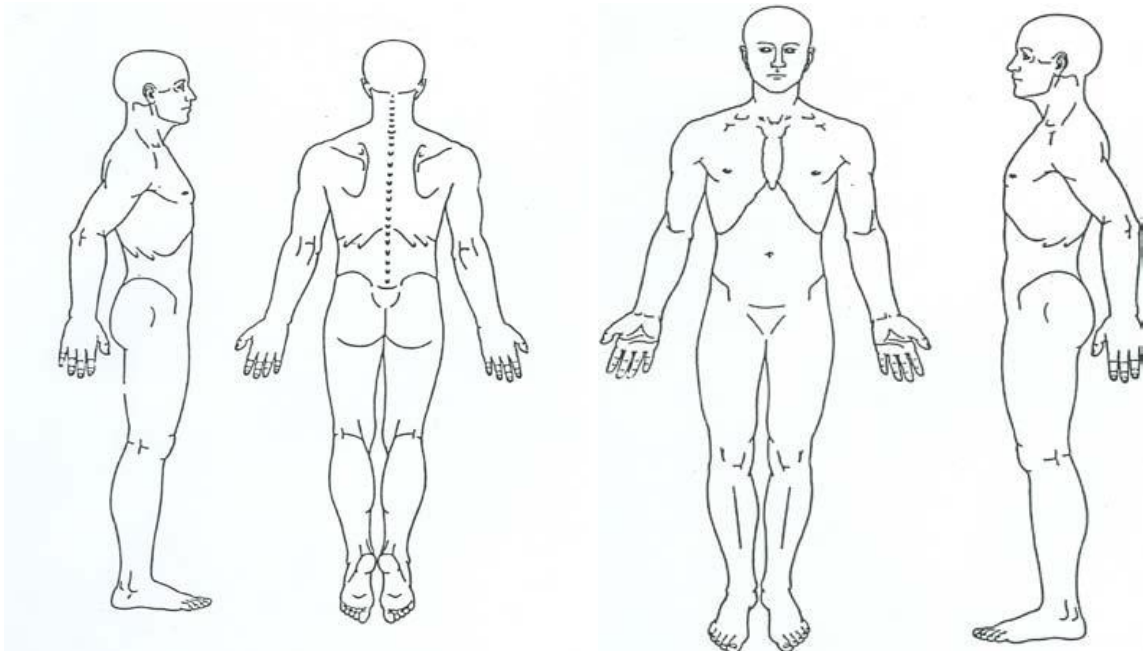
Please list any sports or regular physical activities you do (including cards, gardening, golf, running, bowling, walking, lifting weights or children, bending, sewing, swimming, etc.

_____

Level of Physical Activity: None Light Moderate Heavy

Please **mark** on the body forms with an "X" where you have experienced any pain or other discomfort **in the past week. Please describe the sensation:**

_____



Informed Consent and Disclosure:

I understand that the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity and flexibility. I understand that a massage therapist will never touch genitals, breast tissue or any other areas I instruct them not to touch. I understand that massage therapists do not diagnose illness, disease or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to inform the massage therapist at this time of any conditions I may have and keep the massage therapist informed of any changes in my health and medication in the future. I understand that potential risks of massage include: mild, short-term muscle soreness due to movement of irritating metabolic wastes, and mild surface-level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session. I give consent and authorize the performance of massage therapy techniques and procedures.

Client Signature _____Date_____

Please <u>Initial</u>:

_____I understand that I may be refused treatment if I appear obviously intoxicated or under the influence of drugs.

_____I have read, understand and have been offered a copy of this therapist's HIPAA privacy policy and MN CAP Law Client Bill of Rights.