NEW CLIENT INTAKE FORM Date: _____

Name _____Date of Birth_____ ____

Address_____ _____

Telephone H _____ Telephone (O/M)_____

Best time to call _____Email _____

Occupation: _____Referred by:_____

Have you received massage therapy before today? Yes____ No_____ Date of last massage: _____

What areas would you like to focus on today and/or future sessions? (Circle all that apply)

Stress relief Reduce pain & stiffness Relaxation Reduce muscle tightness

Overall wellness Sports Conditioning Increase ROM Prevention

Other: _____

List the physical activities you enjoy and how often you participate in them.

_____

What are your current health and/or fitness goals? _____

_____

What is your main activity at work or during the day? (Circle all that apply)

Phone work Sitting Computer Work Standing Walking Bending Other: _____

Do you experience any discomfort, pain or limited range of motion doing these activities? (Please explain)

_____

How many hours a day do you spend at work or school? _____

Do you make time in your day or week for fun and relaxation? Yes No Working on it

What types of things do you do to manage stress if/ when it presents itself? _____

Is there anything else you would like to implement regarding wellness that we have not covered on this form?

_____

Medical History Information

Please circle any of the following that apply to your personal health (past or present)

Headaches	Chronic Pain	Varicose Veins	Muscle or Joint Pain
Blood Clots	Sinus problems	Osteoporosis	Numbness/Tingling
Scoliosis	Depression/Chronic Fatigue	High/low blood pressure	TMJ/Jaw Tightness
Arthritis	Sprains/Strains	Diabetes	Cancer/tumors
Neck Pain/Stiffness	Carpal Tunnel	Infectious disease	Stroke
Sciatica	Cardiovascular/Heart Conditions	Insomnia	Low Back Pain
Poor circulation	Kidney issues	Rotator Cuff Injury	Grief
Car accident	Pulmonary disease	Seizures	Parkinson's/MS
Herniated/Bulging Disc	Shingles	Knee Replacement	Hip Replacement

Other: _____

Below list current health care providers (Physician, Chiropractor, Physical Therapist, Other).

Practioner: _____ Phone _____

Practioner: _____ Phone_____

List previous accidents, sports injuries, falls and surgeries (approx. dates).

_____

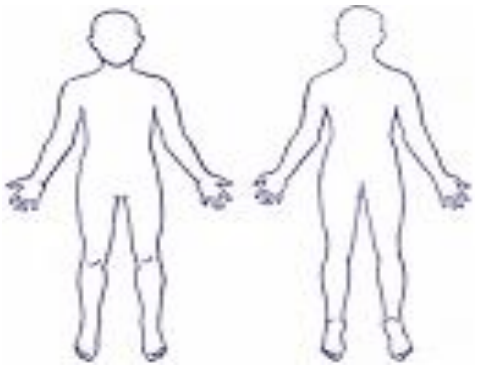
_____

List all the medications you are currently taking and what they are for:

_____

_____

Please place an X on any area causing you current discomfort or are chronic problem areas



Front Back

To the best of my knowledge all the information contained above is accurate. I will agree to keep my therapist updated as heath conditions change. I understand that a massage therapist shall not diagnose a patient's medical condition but evaluate whether the application of massage therapy is advisable. I also understand that a massage therapist may provide treatment, education and evaluation of disorders of the musculature and soft tissue of the human body within their scope of practice.

Signature_____ Date_____

MEDICAL WAIVER & POLICIES FORM:

1. I understand that medical massage is not a substitute of medical examination, diagnosis, or treatment by a physician and nothing said or done in this or following sessions should be construed as such.

2. If I experience any undue pain or discomfort, I will let my therapist know, so she can adjust the technique to meet my needs.

3. Because massage should not be done under certain medical conditions, for the safety and health of the client, I have stated all my known medical conditions honestly and completely.

4. I will give a minimum of 24-hour notice if I need to change or cancel an appointment. I understand this time is set-aside for me and there is no double booking. I understand that payment is due for any scheduled appointment I miss and do not cancel.

5. In the case of a medical or personal emergency I will contact my therapist as soon as possible to avoid being charged for a missed session. I realize this is on a per case basis, and a fee may be charged.

6. Due to the nature of the business I understand that if I arrive late my session will end at its originally scheduled time and payment is due for the full session.

7. In a therapeutic relationship I understand the importance of confidentiality: All clients can expect information obtained in the course of our therapeutic relationship to be kept confidential under HIPPA rules, except with a written consent signed by the client to release information, or if the client discloses information that he/she may be considering harm to themselves or to others.

8. I understand that if I am using a Health Savings Account for Medical Massage that I need to have a physician referral form on file and update it annually.

9. After the massage I understand that toxins are released from the soft tissues during a massage, it is recommended that I drink plenty of water for 24 to 48 hours following my session. If I have any questions or concerns regarding how I feel after my session, I will contact my therapist.

10. By signing below I agree to abide to the above policies:

Signature: _____Date: _____