Massage Therapy

CLIENT INTAKE FORM

PLEASE COMPLETE PRIOR TO TREATMENT

Personal Information

Name: _____

Address: _____

_____

Date of Birth: _____

Weight (lbs): _____

Height (inches): _____

Age: _____

Home/Work Phone: _____

Cell Phone: _____

Occupation: _____

Email: _____

Physician: _____

Insurance Co.: _____

Lawyer: _____

Emergency Contact

Name: _____

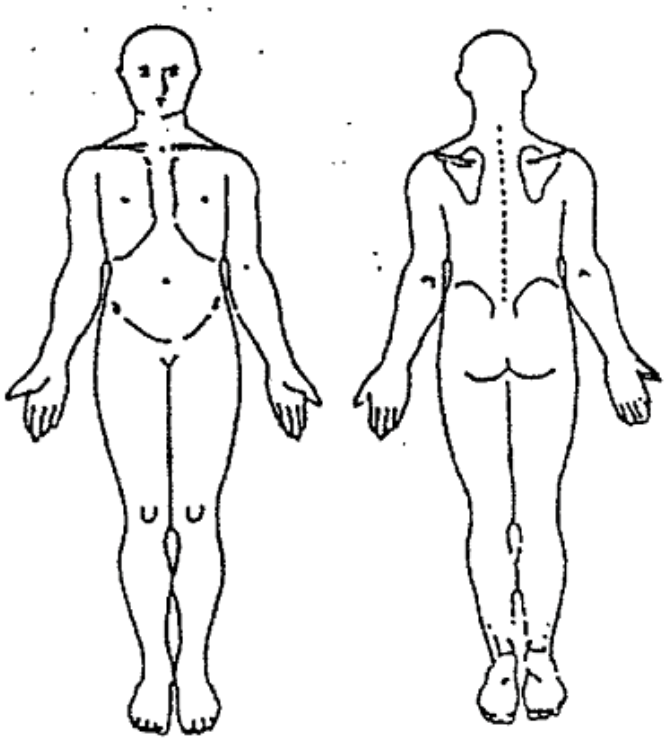
Relationship: _____

Home Phone: _____

Cell Phone: _____

Pain Levels

**Please mark an X on the picture anywhere you have pain, numbness, or tingling:



Rate the severity of pain from 1 (minor pain) to 10 (severe pain): _____

Describe the type of pain:

- ☐ Dull
- ☐ Sharp
- ☐ Stiff
- ☐ Aching
- ☐ Shooting
- ☐ Swelling
- ☐ Burning
- ☐ Numb
- ☐ Cramping
- ☐ Tingling
- ☐ Throbbing
- ☐ Other: _____

How often and when do you have this pain?

_____

Painful activities:

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending
- ☐ Lying Down
- ☐ Other: _____

The pain is always there ☐ The pain comes and goes ☐

Health History

**Please mark any of the following conditions that may apply.

Head & Neck

- Headaches
- Migraine
- Sinus Problems

Respiratory

- Smoking/Quantity
- Shortness of Breath
- Respiratory Illness

Digestive/GU Tract

- Bowel Problems
- Liver/Gallbladder Issues
- Kidney Bladder Issues
- Voiding Problems

Muscles & Joints

- Arthritis
- Osteoporosis
- Fractures
- Artificial Joints/Pins
- Limited Joint Movement
- Stiffness & Numbness
- Swelling
- Sprain/Strain
- Disc Injury

Other

- Hemophilia
- Diabetes
- Hypoglycemia
- Insomnia
- Cancer
- Fibromyalgia
- Chronic Fatigue
- Multiple Sclerosis
- Epilepsy

Infections

- Hepatitis
- HIV/AIDS
- Herpes/Cold Sores
- T.B.
- Plantar Warts
- Athletes Foot
- Cysts
- Other

_____

Cardiovascular

- Varicose Veins
- Blood Clotting
- Poor Circulation
- Low/High Blood Pressure
- Heart Disease
- Stroke

Female-Specific

- Pregnancies
- E.D.C
- Painful Menstruation
- Menopause
- Hysterectomy

Skin Conditions

- Sensitive
- Bruises Easily
- Rash
- Open Sores
- Hot/Cold Sensitive

Other Health Care:

Have you received massage therapy or bodywork before? Yes No

If yes, which of the following have you tried:

Chiropractic Physiotherapy Massage Therapy Acupuncture

Are you on any medication? Yes No

If yes, please list the medications: _____

_____

Do you exercise? Yes No If yes, how many times per week ? _____ How many hours? _____

Other Health Care Details: _____

_____

ACKNOWLEDGEMENT & CONSENT

PLEASE READ CAREFULLY & SIGN BELOW

I hereby request and consent to the performance of Acupuncture, Massage Therapy, and other procedures related to Acupuncture and Massage Therapy if necessary, including needling, moxibustion, cupping, gua sha, laser acupuncture, electro-acupuncture, herbal medicine, Qi Gong, and other techniques within the scope of practice of Traditional Chinese Medicine (TCM), Acupuncture and Massage Therapy.

I have had the opportunity to discuss with the registered acupuncture and massage therapy practitioner the nature and purpose of care and other procedures or alternative care. I understand that results are not guaranteed. I further understand and I am informed that, as in all health care, in the practice of Acupuncture, Massage Therapy and Traditional Chinese Medicine, there are some slight risks to treatment including but not limited to temporary soreness and worsening of symptoms, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the health care professional to be able to anticipate and explain all risks and complications. I wish to rely on the health care professional to exercise judgment during the course of the procedures which are felt at the time, based upon facts then known, to be in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedure(s). I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature _____ **Date** _____