

# Client Intake Form



Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please indicate time of day you can be reached at each number:

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

In case of emergency, please contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

## *Massage Background*

Number of massages received: \_\_\_\_\_ Date of last massage: \_\_\_\_\_

Reason for seeking massage therapy: \_\_\_\_\_

What are your expectations of this massage? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Client Health History

Name: \_\_\_\_\_

Check the following conditions that apply to you, past and present. Please add comments to clarify the condition.

- |  |  |
|--|--|
| <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Dizziness                       |
| <input type="checkbox"/> Joint stiffness / swelling        | <input type="checkbox"/> Shortness of breath             |
| <input type="checkbox"/> Spasms / cramps                   | <input type="checkbox"/> Fainting                        |
| <input type="checkbox"/> Broken / fractured bones          | <input type="checkbox"/> Swollen ankles / Edema          |
| <input type="checkbox"/> Back, hip pain                    | <input type="checkbox"/> Pressure sores                  |
| <input type="checkbox"/> Shoulder / neck / arm / hand pain | <input type="checkbox"/> Varicose veins                  |
| <input type="checkbox"/> Leg / foot pain                   | <input type="checkbox"/> Blood clots / blood thinner use |
| <input type="checkbox"/> Jaw pain / TMJ disorder           | <input type="checkbox"/> DVT                             |
| <input type="checkbox"/> Tendonitis                        | <input type="checkbox"/> Cardiac / circulatory problems  |
| <input type="checkbox"/> Bursitis                          | <input type="checkbox"/> Allergies                       |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Stroke / TIA                    |
| <input type="checkbox"/> Osteoporosis                      | <input type="checkbox"/> History of Cancer               |
| <input type="checkbox"/> Spinal Deformity _____            | What type: _____   |
| <input type="checkbox"/> Sinus Problems _____              | Treatment: _____   |
| <input type="checkbox"/> Asthma _____                      | Lymph Nodes removed: ____ # _____                        |
- 
- |   |  |
|---|--|
| <input type="checkbox"/> Rashes                   | <input type="checkbox"/> Nervous stomach           |
| <input type="checkbox"/> Athlete's foot           | <input type="checkbox"/> Indigestion               |
| <input type="checkbox"/> Warts                    | <input type="checkbox"/> Constipation              |
| <input type="checkbox"/> Moles                    | <input type="checkbox"/> Intestinal gas / bloating |
| <input type="checkbox"/> Numbness / tingling      | <input type="checkbox"/> Diarrhea                  |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Irritable Bowel Syndrome  |
| <input type="checkbox"/> Chronic pain             | <input type="checkbox"/> Crohn's Disease           |
| <input type="checkbox"/> Sleep disorders          | <input type="checkbox"/> Colitis                   |
| <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> Pregnant                  |
| <input type="checkbox"/> Paralysis                | <input type="checkbox"/> PMS                       |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Menopause                 |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Fertility concerns        |
| <input type="checkbox"/> Hearing Impairment       | <input type="checkbox"/> Difficulty concentrating  |
| <input type="checkbox"/> Fibromyalgia _____       | <input type="checkbox"/> Alcohol use _____         |
| <input type="checkbox"/> Diabetes _____           | <input type="checkbox"/> Caffeine use _____        |
| <input type="checkbox"/> Whiplash                 | <input type="checkbox"/> Frequent stress           |
| <input type="checkbox"/> Other _____              |  |

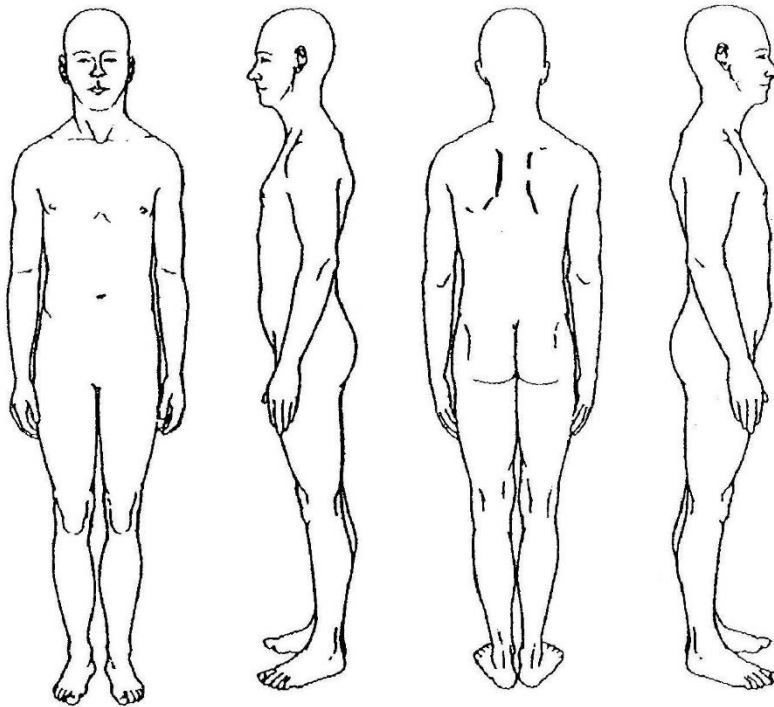
Please list any accidents or operations with date and description: \_\_\_\_\_

List any medications (including aspirin) and the reason you are taking them: \_\_\_\_\_

Please list any nutritional supplements you are taking: \_\_\_\_\_

Please identify current problem areas in your body by making the appropriate marks on the figures below.

XXXXXX – areas where pain exists



Additional Comments: \_\_\_\_\_

**If you have a specific medical condition or symptom, massage therapy may be contraindicated. The massage therapists of Charter Health Center may require a referral from your primary care provider before service is provided.**

**CANCELLATION AND MISSED APPOINTMENT POLICY**

You may cancel your appointment without charge up until 2 hours before your appointment time. If you do not call to cancel your appointment and do not show for your scheduled appointment, you will be charged the full price for the scheduled service and future service will be denied until payment is made.

**LATE ARRIVAL POLICY**

If you arrive late to your appointment, your session will still end at the scheduled time. Your therapist will determine if there is enough time remaining to start a partial treatment. Regardless of the length of the treatment given, you will be responsible for the full session. This time is reserved for only you, and there are appointments scheduled after yours that must begin on time. Out of respect and consideration for your therapist, please plan accordingly. Be on time and ready.

**CLIENT AGREEMENT**

I understand that the bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. Thus, the bodywork I receive shall not be considered a substitute for medical examination, diagnosis or treatment by a qualified physician, chiropractor or other specialist. I understand that massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe or treat any physical or mental illness and nothing said in the course of the session will be construed as such. Because certain physical conditions may contraindicate massage, I certify that the health information I have provided is accurate and I agree to update the Center of any changes in this condition. I understand that my failure to do so is not the liability of the Center or the practitioner. I agree to the Cancellation and Missed Appointment Policy and the Late Arrival Policy. **I also understand that any illicit or sexually suggestive remarks or advances will terminate the session and payment in full will be expected.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give consent for \_\_\_\_\_, a minor, to receive massage services.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_