BODYWORK INTAKE FORM

THESE NOTES ARE PRIVATE AND YOUR SECURITY IS VALUED.

Client Information

Name: _____ Pronoun(s): _____ Date of Birth _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

E-mail:_____ Occupation: _____

Emergency Contact: _____ Phone: _____

Massage History/Session Information

Have you received a massage before? Y__ N__ When? _____ Frequency? _____

What did you like about your treatment _____

What didn't you like about your treatment _____

What kind of touch do you like? Light ____ Medium ____ Deep ____ Combo ____

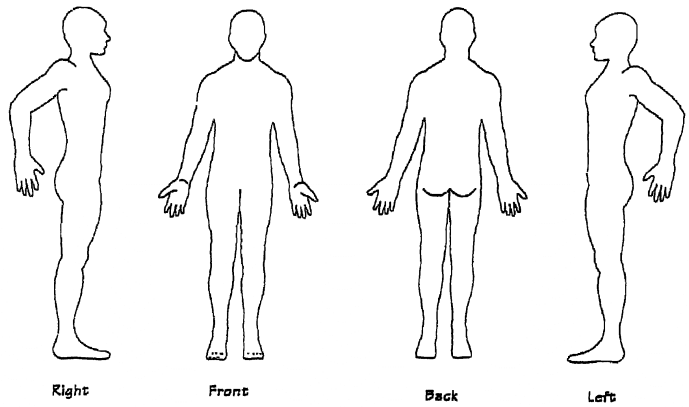
Purposes of massage today (relaxation/addressing an injury) _____

_____

Description of injury _____

_____

_____



1. Circle any specific areas you would like the massage therapist to concentrate on during the session.

2. Use provided letters to indicate
   P- pain or tenderness
   S- joint or muscle stiffness
   N- numbness or tingling

3. Please mark on the line below the level of your discomfort/pain

_____

0 10

No pain Worst Pain

Health Information

Please mark an (X) by all current conditions and (P) for all past conditions:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity

( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/ osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy

( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy, if yes, how many months _____

Other_____

Elaborate on noted areas above:

_____
_____
_____

Do you wear a Hearing Aid? _____ Contacts? _____ Dentures? _____Pacemaker?_____

Please list your stress-reduction activities, hobbies, exercise and/or sport participation:

_____
_____

THANK YOU FOR THE TRUST. FEEL FREE TO EMAIL AN (ENCRYPTED) VERSION OF THIS DOCUMENT OR ARRIVE EARLY TO YOUR SCHEDULED SESSION TO FILL OUT. ALL CLIENTS ARE REQUIRED TO DO SO ONCE PER YEAR.

- I understand that therapeutic massage should not be done under certain medical conditions; I affirm that I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.
- I understand that massage therapist can not diagnose illness, disease, or any other medical, physical, or emotional disorder. I am responsible for consulting a qualified physician for any physical ailments that I have.
- I understand that massage therapy is a therapeutic health aid and is non-sexual. Any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
- I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or during next appointment or will reduce my fee accordingly.
- I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.
- I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.
- I agree to pay in full at the time of my treatment, unless other arrangements are made in advance.

Client signature: _____ Date _____