##### CONFIDENTIAL CLIENT INTAKE FORM

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill out all information as accurately and thoroughly as possible.

## It is better that you give me what you consider too much information, rather than not give enough.

##### Personal Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home) (Cell) Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:  Single  Widowed  Divorced  Married Anniversary Date: \_\_\_\_\_\_

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

Emergency Contact: (Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Relationship) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home) ­ (Cell)

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Opt-in for Email and Text Communication:  Y  N

###### Massage Information

1. Have you had a professional massage before? If so, when was your last session? \_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you wearing:  Contact lenses  Dentures  Hearing Device
3. Do you sit for long hours at a computer workstation, computer, or driving?  YES  NO

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you perform any repetitive movement in your work, sports, or hobby?  YES  NO

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you experience stress in your work, family, or other aspect of your life?  YES  NO

If yes, how do you think it has affected your health?

Muscle Tension  Anxiety  Insomnia  Irritability  Other

1. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort?

YES  NO If yes, please identity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any particular goals in mind for this massage session?  YES  NO

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Medical History

1. Are you currently under the care of a physician or other healthcare practitioner?  YES  NO

If yes, for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you utilize the services of a chiropractor?  YES  NO

If yes, who? (Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last session? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you taking any prescription or over-the-counter medications or dietary supplements?

If so, please list the medication and when you last took a dose:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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###### Health History

Please check any condition listed below that applies to you:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Headaches/Migraines |  | Recent Fracture |  | Strains, Sprains |
|  | Jaw pain / TMJ |  | Inflammation |  | Bone or Joint Disease |
|  | Artificial Joint |  | Gout |  | Plantar Fascitis |
|  | Whiplash |  | Chronic Pain, where? |  | Osteoporosis |
|  | Contagious Skin Condition |  | Rashes |  | Athlete’s Foot |
|  | Warts |  | Open Sores or Wounds |  | Eczema / Dermatitis |
|  | Psoriasis |  | Numbness Tingling |  | Epilepsy |
|  | Pregnancy |  | Depression |  | Hearing or Vision Impairment |
|  | Diabetes |  | Fibromyalgia |  | Cancer |
|  | Grieving |  | Anxiety / Panic Attacks |  | Dizziness |
|  | Pneumonia |  | Shortness of Breath |  | Stroke |
|  | Heart Condition |  | Sinus Problems |  | Asthma |
|  | High / Low Blood Pressure |  | Carpal Tunnel Syndrome |  | Hemophilia |
|  | Current Fever |  | Swollen Glands |  | Varicose Veins |
|  | Atherosclerosis |  | Blood Clots |  |  |

###### Client Responsibilities

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist’s part should I fail to do so.

###### Consent to Treatment of a Minor:

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session.

By my signature below, I hereby authorize therapists from Manuel Touch Massage Therapy to administer therapy techniques to my child or dependent as deemed necessary.

Check here to signify parental consent

Signature of Client or Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_