Intake Form

Dear Client,

Please take a few moments to complete this form. The information provided is voluntary on your part. It is not intended for disclosure or dissemination and will be treated as confidential.

Name: _______________________________________ Date: _______________

GOAL for visit: ____
Target areas to work on: ____
General Health: ____
Energy level: ______________________________
Exercise program (type & frequency): ____

Please answer or mark a 'check' in the appropriate area for each question:

When was your last massage? ____

What position do you spend most of your day in? ____ Standing ____ Sitting ____Both

Occupation: _________________________________

How much "checking in" about pressure, style and focus of contact do you like during your massage? ____ None ____Some ____ A lot

YES	NO	N/A
		How would you describe your stress level?: Low ___ , Med. ____ , High ____
____	____	How frequently do you experience headaches?
____	____	____ Are you pregnant? If so, how far along are you? _____________
____	____	Do you have children that you pick up and carry?
____	____	Are you epileptic?
____	____	Do you have high blood pressure?
____	____	Do you have varicose veins or blood clots?
____	____	Are you currently taking medications, including aspirin or NSAIDS? If so, please describe (their names & purposes)__________________________________ ____
____	____	Have you ever had surgery? If so, please describe: When: __________ For what? ______________________________________ How was the recovery? (Length of time, quality of recover) _______ ____ If you have any lasting effects from this/these, what are they? ____

YES NO

____ ____ Have you ever dislocated a shoulder? If so, which one and when? ______
____
____ ____ Have you ever broken any bones? If so, when? ______________________
Which ones? ____
What discomfort / issue lingers from these? _____________________
____
____ ____ Have you ever been in a car accident? If so, when? __________________
What injury did you experience? ____________________________
What treatment did you do? ________________________________
What pain lingers/recurs from this/these accident/s? _________________
____
____
____ ____ Have you ever had any other serious accidents where you were injured?
If so, what and when? _____________________________________
____ ____ Do you have cardiac or respiratory problems? Explain: ________________
____ ____ Do you have back pain? If so, where in your back? ______________
____ ____ Do you experience neck pain? If so, where in your neck? ______________
____ ____ Do you have any limitations of mobility? If so, what/where? ________________
____ ____ Do you have any tension or soreness in any other specific area?
If so, where? ____
And is this discomfort chronic or does it come and go? (please circle appropriate response)
____ ____ In the past month have you had any injuries? Sprained, or bruised anything? If so, what and when? ____________________________
____ ____ Do you have any cuts, rashes, or open sores today? If so, where? _______
____ ____ Do you have any numbness or stabbing pains anywhere?
If so, where? ____
____ ____ Are you very sensitive to touch/pressure in any particular body area?
If so, where? ____
____ ____ Are you allergic to any products in oils or lotions? If so, which?
____
____ ____ Do you have any other medical condition I should be aware of?
If so, what? ____
____ ____ Is there anything else you would like me to be aware of?
If so, what? ____

Any questions you answered affirmatively to will be discussed with you prior to your session.

Please be informed that it is the client's sole responsibility to inform the practitioner of any changes in the client's health-related profile.

Please take a moment to Carefully Read and Understand the following information. Please acknowledge and sign where indicated. You will not be asked to sign this form again, unless changes occur in your health information.

510.418.4262

Client Contact Sheet

Name: ___________________________ Date: ____________

Street Address: ___________________________

City: ___________________________ Zip: _______________

Birth Day and Month: __________________

Best Way to contact? Call or Text or E-mail ?

Work phone: ___________________ Home Phone: ______________

Cell phone: ___________________ Do you text message? _____

Email Address: ___________________________

Best time to contact: ___________________________

Best time for appointment: ___________________________

Preference for Male or Female therapist: ___________________________

Referred by: ______________________

Emergency contact:

Name: ___________________________ Relationship: ___________________________

Best Way to contact: Call Work / Home / Cell / Text / E-mail

And That contact number or email: __________________________

RELEASE: Please check-off on each item you understand, print your name above and sign and date below.

Name (please print): ____

❒ Cancellation: I understand that a 24-hour notice of cancellation is required or I will be liable for full payment of the missed appointment.

If I am sick 24-48 hours before my appointment, I will call 510.418.4262 to reschedule. If I am unsure how sick is "sick", I will call to discuss my condition with the practitioner. If I do not call and, instead, show up sick to my appointment, I understand that the practitioner may decline service to protect my health, their health and the health of their other clients and, in such an event, that I will be charged the full rate of the appointment.

❒ Comfort: I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately and clearly inform the practitioner so that the pressure and/or strokes may be adjusted to my communicated level of comfort.

❒ Appropriate care: I understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should consult a physician, chiropractor, physical therapist, or other qualified medical specialist for any mental or physical ailment of which I am aware. I further understand that the practitioner is not a 'provider of health care' for any purpose.

I also understand that massage therapists/bodyworkers are not qualified to perform spinal or skeletal adjustments, or diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) should be construed as such.

❒ Confidentiality: I understand that the information about my health and the content of these sessions will be confidential unless any of the information represents a threat to my own life or the life of another, or unless I have given the practitioner consent to share my health-related information with a health-care provider.

❒ Liability: I understand that massage/bodywork is contraindicated (should not be done) under certain medical conditions. Therefore, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile as represented by me, and understand that there shall be no liability on the practitioner's part should I fail, for whatever reason, to do so.

❒ Professionalism: I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the full rate of the appointment.

❒ Integrity: I further understand, acknowledge and certify that all the foregoing is true to the best of my knowledge and belief, and that I presently have no condition that would make this release anything other than knowing and voluntary.

Your signature: ____ Date: _____________