

## CLIENT INTAKE FORM

Please answer the following questions as accurately as possible.

The information provided will be helpful in creating treatment sessions that meet your specific needs.

### PERSONAL INFORMATION:

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

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

\_\_\_\_\_

Telephone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who referred you for treatment? \_\_\_\_\_

### MEDICAL INFORMATION:

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Primary Physician or Chiropractor: \_\_\_\_\_

What is the PRIMARY complaint that brings you in for treatment today? \_\_\_\_\_

\_\_\_\_\_

Any secondary complaints you would like to address? \_\_\_\_\_

\_\_\_\_\_

Please describe any pain, limited range of motion or difficulty with activities due to your symptoms: \_\_\_\_\_

\_\_\_\_\_

How and when did these issues begin? \_\_\_\_\_

\_\_\_\_\_

Please list history of trauma (physical or emotional), accidents or surgery: \_\_\_\_\_

\_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please check any of the conditions you've had in the past or currently have:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cardiovascular Disease       | <input type="checkbox"/> Neurological Condition    | <input type="checkbox"/> Sinus Problems         |
| <input type="checkbox"/> Arthritis (Osteo/ Rheum)     | <input type="checkbox"/> Depression                | <input type="checkbox"/> Anxiety                |
| <input type="checkbox"/> Asthma/ Difficulty Breathing | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Constipation/ Diarrhea |
| <input type="checkbox"/> Vertigo/ Dizziness           | <input type="checkbox"/> Varicose Veins            | <input type="checkbox"/> Digestive Problems     |
| <input type="checkbox"/> Thyroid Condition            | <input type="checkbox"/> Diabetes (Type 1 or 2)    | <input type="checkbox"/> Pregnancy              |
| <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> Multiple Sclerosis        | <input type="checkbox"/> Numbness/ Tingling     |
| <input type="checkbox"/> HIV/AIDS                     | <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Tendonitis             |
| <input type="checkbox"/> Chronic Infections           | <input type="checkbox"/> Epilepsy/ Seizures        | <input type="checkbox"/> Sprains/ Strains       |
| <input type="checkbox"/> Kidney Disease               | <input type="checkbox"/> Chronic Fatigue Syndrome  | <input type="checkbox"/> Muscle/ Joint Pain     |
| <input type="checkbox"/> Congestive Heart Failure     | <input type="checkbox"/> Headaches/ Migraines      | <input type="checkbox"/> Blood Clots            |
| <input type="checkbox"/> Tension/ Stress              | <input type="checkbox"/> Back or Neck Pain         | <input type="checkbox"/> Rash/ Skin Conditions  |
| <input type="checkbox"/> Sleep Disorders              | <input type="checkbox"/> Chest Pain/ Tightness     | <input type="checkbox"/> Eyestrain/ Irritation  |
| <input type="checkbox"/> TMJ/Jaw Pain                 | <input type="checkbox"/> Earaches/ Ringing in Ears | <input type="checkbox"/> Menstrual Issues       |

**I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/ HEALTH STATUS SHOULD CHANGE, I WILL INFORM MY THERAPIST IMMEDIATELY.**

I understand myofascial release/ bodywork may be contraindicated. A referral from my primary care physician may be required. I further understand that bodywork 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 is beyond the scope of practice of my massage therapist. I understand that massage/ bodywork practitioners 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 should be construed as such. Because myofascial release/ massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and have answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so. It is also my understanding 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 full payment of the scheduled appointment. I understand I will be charged for appointments I cancel or miss without 24 hours notice of my scheduled appointment. I also understand that if I arrive late I will receive the remainder of the time scheduled, but will be liable for payment in full.

**Client Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Signature of Parent or Guardian to treat a minor** \_\_\_\_\_

**PLEASE INDICATE AREAS OF PAIN, TENSION AND/OR DYSFUNCTION.**

Draw or highlight to show where you feel pain or tension, have limited range of motion, or areas that create dysfunctional symptoms.

