Client Intake Form – Therapeutic Massage

Personal Information:

Name_____Today's Date_____

Home Phone_____CellPhone_____Work Phone_____

Address_____

City/State/Zip_____

Email_____Date of Birth_____/_____/_____ Gender_____

Emergency Contact_____Phone_____

Physician/Healthcare Provider:_____Phone_____

How did you hear about us?_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Please state your Occupation, if any and describe typical activities of daily living.

_____

_____

2. Have you had a professional massage before? Yes No
   If yes, how often do you receive massage therapy?_____

3. Do you have any allergies especially to oils, lotions, or ointments? Yes No
   If yes, please explain_____

4. Are you currently taking any medications and/or supplements? Yes No
   If yes, please list_____

5. Are you currently Pregnant? Yes No
   If yes, what is the due date?_____

6. Do you have sensitive skin? Yes No

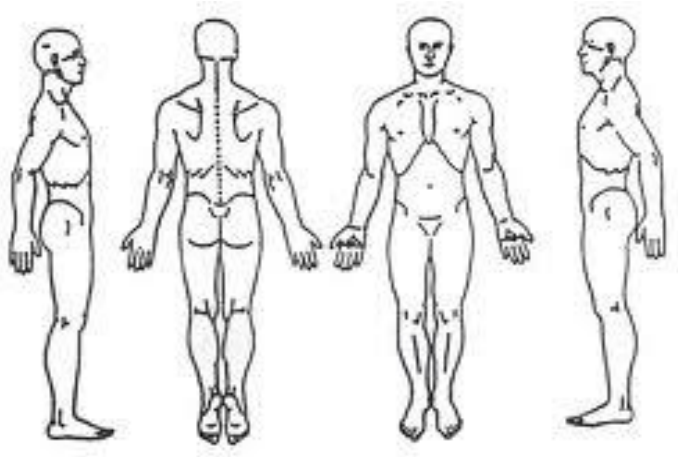
7. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

8. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe_____

9. Have you had any injuries or surgeries in the past that may influence today's treatment? Yes No
   If yes, please explain_____

10. Indicate any specific areas that are giving you current concern, or that you would like the massage therapist to concentrate on during the session:

P = Pain, ache, tenderness
S= Stiffness in the joint or muscle



11. Rate how you are feeling today by drawing a circle around the number that best represents how you are doing today:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable
Able to do Everything	0	1	2	3	4	5	6	7	8	9	10	Not Able to do Anything

12. Please check any health condition listed below that <u>currently</u> applies to you.

( ) contagious diseases
( ) infections
( ) blood clots
( ) pitted edema
( ) congestive heart failure
( ) **None of the above applies to me**

Please explain any condition that you have marked above
_____
_____
_____

13. Please circle if you have had any conditions stated below in the past or are currently experiencing these conditions.

Current	Past	Muscle or joint pain	Current	Past	Cancer
Current	Past	Muscle or joint stiffness	Current	Past	Neurological (e.g. MS, Parkinson's, chronic pain)
Current	Past	Numbness or tingling	Current	Past	Memory Loss, confusion, easily overwhelmed
Current	Past	Swelling	Current	Past	Epilepsy, seizures
Current	Past	Bruise easily	Current	Past	Headaches, Migraines
Current	Past	Sensitive to touch	Current	Past	Dizziness, ringing in the ears
Current	Past	High/Low blood pressure	Current	Past	Digestive conditions (e.g. Crohn's IBS)
Current	Past	Stroke, Heart attack	Current	Past	Gas, bloating, constipation
Current	Past	Varicose vein	Current	Past	Kidney disease, infection
Current	Past	Deep vein thrombosis	Current	Past	Arthritis (rheumatoid, osteoarthritis)
Current	Past	Diabetes	Current	Past	Osteoporosis, degenerative spine/disk
Current	Past	Endocrine/thyroid conditions	Current	Past	Scoliosis
Current	Past	Depression, anxiety	Current	Past	Broken bones
Current	Past	Shortness of breath			

( ) **None of the above applies to me**

Please explain in detail, including treatment received on the **current** conditions you have marked above

_____
_____

14. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____
_____
_____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/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 of which I am aware. 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 given should be construed as such. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also 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 scheduled appointment. Understanding all of this, I give my consent to receive care.

Ideal Chiropractic & Therapeutic Massage Cancellation Policy

All appointments must be cancelled by 3 p.m. of the previous day (or by 12 p.m. on Friday for a Monday appointment), to avoid a $30.00 no-show or late-cancellation fee. After-hour messages regarding cancellations may be left at (920) 907-1700.

By signing below, you acknowledge that you read and understand the policies stated above.

Print Name _____

Signature of client_____ Date_____

Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 18.