

Bodywork Client Intake — page 1

Name _____ Date _____
 Date Of Birth: _____ Age: _____ Sex: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: (home) _____ (work) _____
 Occupation _____ SS# _____
 Insurance Co. _____ Date of Injury _____ Claim # _____
 Referred by _____

What is the main reason for this visit? _____
 Have you received massage before? ____ Yes ____ No Frequency (if yes): _____
 likes: _____
 dislikes: _____

Please list all accidents, injuries or surgeries and the date of each:

Are you receiving medical treatment? ____ Yes ____ No
 If yes, please give practitioner name, title and reason:

Are you taking any medication? ____ Yes ____ No
 If yes, please explain:

Do you wear contact lenses? ____ Yes ____ No

Are you currently experiencing any of the following conditions/symptoms:

<input type="checkbox"/> heart trouble	<input type="checkbox"/> inflammation	<input type="checkbox"/> allergies	<input type="checkbox"/> pregnancy
<input type="checkbox"/> varicose veins	<input type="checkbox"/> infection	<input type="checkbox"/> skin conditions	<input type="checkbox"/> menstrual problems
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> broken bones	<input type="checkbox"/> rashes	<input type="checkbox"/> HIV positive
<input type="checkbox"/> cancer	<input type="checkbox"/> sciatica	<input type="checkbox"/> fever	<input type="checkbox"/> sleep difficulties
<input type="checkbox"/> MS	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> diarrhea	<input type="checkbox"/> chronic fatigue
<input type="checkbox"/> diabetes	<input type="checkbox"/> arthritis	<input type="checkbox"/> constipation	<input type="checkbox"/> intense stress
<input type="checkbox"/> epilepsy/seizures	<input type="checkbox"/> bursitis/tendonitis	<input type="checkbox"/> herpes virus	<input type="checkbox"/> headaches
<input type="checkbox"/> contagious disease	<input type="checkbox"/> disc problems	<input type="checkbox"/> cold or flu	<input type="checkbox"/> other

Please explain:

Habits:	heavy	moderate	light	none
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Water	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

Massage Client Intake Form — page 2

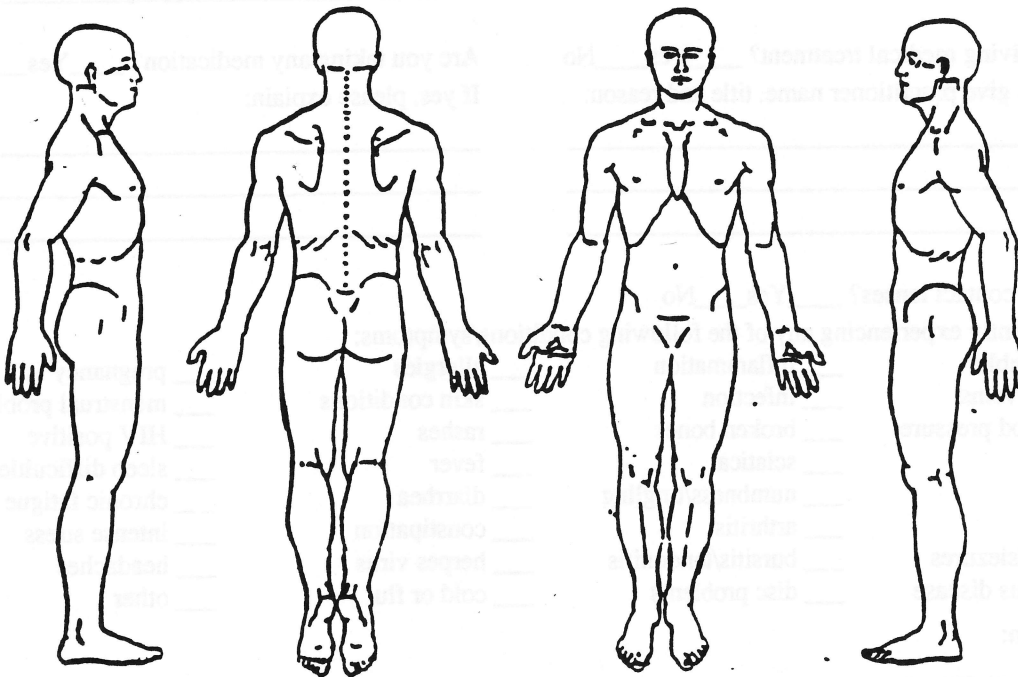
Chief complaints: _____

Where do you tend to hold stress in your body?

Postural/movement observations (therapist to fill in):

What aggravates your condition? _____

Please indicate your areas of pain, tenderness, tension, etc. on the figures below:



I acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information for medical or insurance purposes. I authorize Sarah Ellis, LMP to obtain any information from my primary health care providers concerning my health. I understand that massage therapy treatments are my personal financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made. I also understand that I will be charged for any appointment broken with less than 24 hours notice.

Signature: _____ Date: _____