client intake form

Jessica Buuck, CMT #42345

personal information

name _____ date of birth _____

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

work phone _____ ext. _____

email _____

Would you like to receive emails about discounts, specials, and the referral program?
❒ Y ❒ N

occupation _____

emergency contact name (relationship) _____ emergency contact phone _____

physician's name _____ physician's phone _____

massage experience

Have you had a professional massage before? ❒ Yes ❒ No

If yes, when was your last massage? _____

What are your goals for treatment? _____

health history

Please fill this out carefully, even if some of the conditions or symptoms don't seem connected to your current issue.

Musculoskeletal
___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory
___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory
___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify: _____
___ Sinus Problems

Nervous System
___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Reproductive
___ Pregnant, stage _____
___ Ovarian/Menstrual Problems
___ Prostate

current health

Do you exercise regularly and/or participate in any sports? ❒ Y ❒ N
If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? ❒ Y ❒ N
If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? ❒ Y ❒ N
If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? ❒ Y ❒ N
If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? ❒ Y ❒ N
If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? ❒ Y ❒ N
If yes, describe _____

Do you have sensitive skin? ❒ Y ❒ N

Do you have any allergies to oils, lotions or ointments? ❒ Y ❒ N
If yes, please explain _____

List any medications you are currently taking _____

Skin
___ Allergies, specify: _____
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

Digestive
___ Irritable Bowel Syndrome
___ Bladder/Kidney Ailment
___ Colitis
___ Crohn's Disease
___ Ulcers

Psychological
___ Anxiety/Stress Syndrome
___ Depression

Other
___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed: _____

Please explain any of the conditions that you have marked above :

client agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that the client or massage therapist may request a change in treatment or behavior or end the session if either is experiencing discomfort due to inappropriate or potentially harmful client/therapist interaction.

signature _____ date _____

Current Complaints

Circle the areas you would like to focus on, and mark any specific problem spots.
Please describe what you're feeling in your problem areas: sore, aching, burning, sharp, numbness, tingling, stiffness, swelling, etc.

List any areas you want to avoid:

Health History

Please mark any past injuries or surgeries with an "X" and write down what they were and approximately what date they occurred.