Confidential Client Intake Form Date: _____

Patient Information

First name: _____ Last name: _____

Address: _____

Email: _____

Home phone: _____ Cell Phone: _____

Date of birth: _____ Gender: _____ Occupation: _____

Emergency Contact: _____

General and Medical Information

Y N Have you had a professional massage and/or lymph drainage before?
If yes, how often? _____

Y N Are you pregnant? If yes, how many weeks? _____

Y N Have you ever had surgery? When and what kind ? _____
_____

Y N Do you exercise regularly? If yes, what types? _____

What is your typical stress level ? (1-10, 10 being high stress)_____

What are your stress triggers? _____

Are you currently on medication? Please list: _____
_____

Are you currently seeing any of the following? (circle all that pertain):
chiropractor / medical doctor / naturopathic doctor / physiotherapist / acupuncturist / psychologist

Please check all that apply:

General __ allergies __ cancer __ recent dental surgery __ diabetes __ fibromyalgia __ headache/migraines __ AIDS/HIV __ infectious conditions __ kidney problems **Musculoskeletal** __ arthritis __ carpel tunnel syndrome __ jaw pain, TMJD __ joint replacement __ muscle/joint pain or injury __ osteoporosis __ sprains/strains	**Cardiovascular** __ blood clots __ heart problems __ high/low blood pressure __ poor circulation __ varicose veins **Respiratory** __ asthma, lung condition __ cold/flu __ sinusitis, sinus problems **Digestive** __ abdominal pain __ constipation __ diarrhea __ digestive disorder __ irritable bowel syndrome	**Skin** __ eczema __ fungal infection __ psoriasis __ rash __ acne **Nervous System** __ depression __ dizziness __ epilepsy __ numbness/tingling __ sciatica __ sleep difficulties **Reproductive** __ painful menstruation

Other medical conditions not listed? please specify:

_____

_____

Massage information

What type of massage pressure do you prefer? (circle): deep /moderate/ light.

Is there an area you would prefer not to be massaged? _____

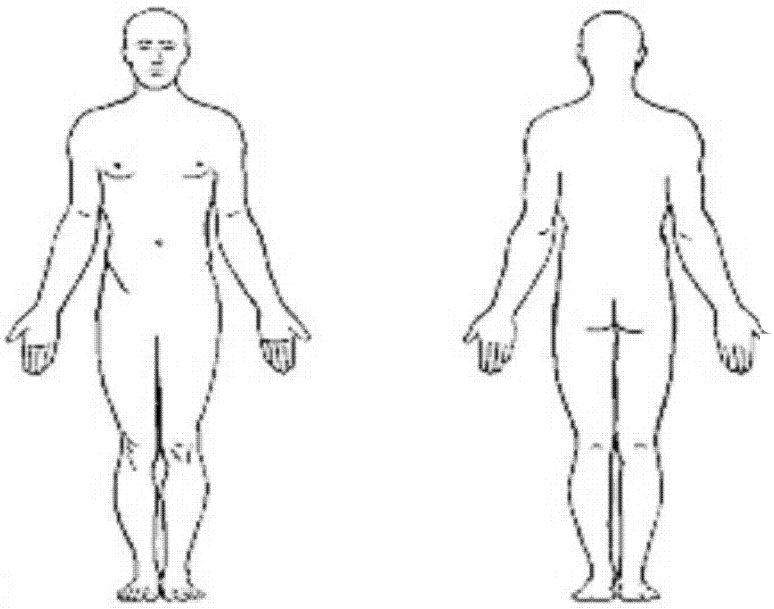
_____

What is the specific area of concern or goals, you wish to achieve from this treatment?

_____

_____

Shade all areas of typical pain/discomfort/concern:



How did the symptoms begin and when did they start? _____

_____

What relieves the symptoms? _____

What aggravates the symptoms? _____

Client Waiver Form

I acknowledge that the therapist is not a physician and does not diagnose illness or disease, or any other physical or mental disorder. I clearly understand that massage/ CranioSacral therapy is not a substitute for a medical examination. It is recommended that I attend my primary doctor for any ailments that I may be experiencing. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical form, as provided by my therapist, and disclosed all of those medical conditions affecting me. It is my responsibility to keep my massage therapist updated on my medical history. The information I have provided is true and complete, to the best of my knowledge. By signing this form, I consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist.

Client's Name(Please Print): _____

Signature of Client or Guardian: _____

Date: _____ Signature of Vanessa Clark: _____