

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:

<p>General <input type="checkbox"/> allergies <input type="checkbox"/> cancer <input type="checkbox"/> recent dental surgery <input type="checkbox"/> diabetes <input type="checkbox"/> fibromyalgia <input type="checkbox"/> headache/migraines <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> infectious conditions <input type="checkbox"/> kidney problems</p> <p>Musculoskeletal <input type="checkbox"/> arthritis <input type="checkbox"/> carpal tunnel syndrome <input type="checkbox"/> jaw pain, TMJD <input type="checkbox"/> joint replacement <input type="checkbox"/> muscle/joint pain or injury <input type="checkbox"/> osteoporosis <input type="checkbox"/> sprains/strains</p>	<p>Cardiovascular <input type="checkbox"/> blood clots <input type="checkbox"/> heart problems <input type="checkbox"/> high/low blood pressure <input type="checkbox"/> poor circulation <input type="checkbox"/> varicose veins</p> <p>Respiratory <input type="checkbox"/> asthma, lung condition <input type="checkbox"/> cold/flu <input type="checkbox"/> sinusitis, sinus problems</p> <p>Digestive <input type="checkbox"/> abdominal pain <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> digestive disorder <input type="checkbox"/> irritable bowel syndrome</p>	<p>Skin <input type="checkbox"/> eczema <input type="checkbox"/> fungal infection <input type="checkbox"/> psoriasis <input type="checkbox"/> rash <input type="checkbox"/> acne</p> <p>Nervous System <input type="checkbox"/> depression <input type="checkbox"/> dizziness <input type="checkbox"/> epilepsy <input type="checkbox"/> numbness/tingling <input type="checkbox"/> sciatica <input type="checkbox"/> sleep difficulties</p> <p>Reproductive <input type="checkbox"/> painful menstruation</p>
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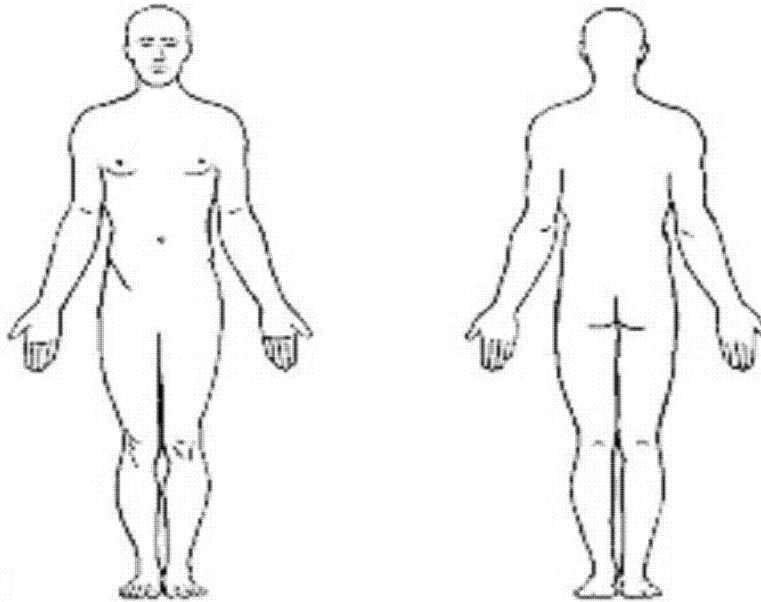
Other medical conditions not listed? please specify:

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 therapy/lymph drainage 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 Yollybelle Camelotes: _____