CLIENT INTAKE FORM

PERSONAL INFORMATION

NAME: _____

EMAIL: _____

ADDRESS: _____ *CITY:* _____ *STATE:* ____ *ZIP:* _____

AGE: _____ *DOB:* _____ *HEIGHT:* _____ *WEIGHT:* _____ *GENDER:* _____

PHONE: _____ *CELL:* _____ *TEXT OK?* *Y / N*

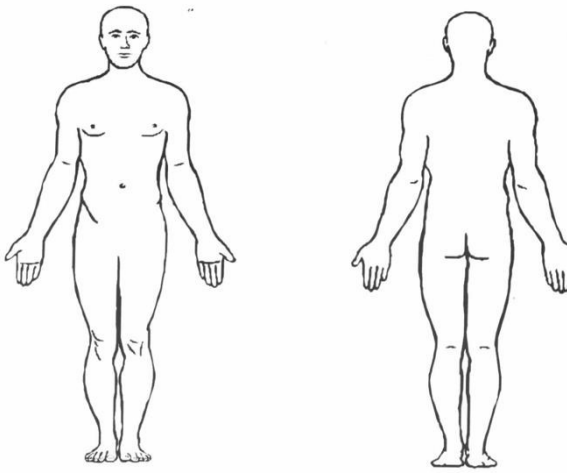
HOW DID YOU FIND US? _____ *REFERRED BY:* _____
OCCUPATION: _____

_

MEDICAL INFORMATION

*Any recent INJURIES:*_____
_____
*Any recent SURGERIES:*_____
_____ *Current MEDICATIONS:*_____
_____
INJECTIONS in last 30 days? *Y / N* *If yes, What/where in the body?*_____
_____
LADIES, are you pregnant? *Y / N*
If yes, how far along? _____ *Or are you trying?* *Y / N*

MARK AREAS OF DISCOMFORT



PLEASE 'X' ANY CONDITIONS BELOW THAT APPLY TO YOU:

__Acute Pain	*__Fluid retention*	*__Osteoarthritis*
__Arthritis	*__Fibromyalgia*	*__Osteoporosis*
__Blood clots	*__Headaches/ migraines*	*__Rheumatoid Arthritis*
__Bulging or Herniated disc(s)	*__Heart attack*	*__Sciatica*
__Bursitis	*__Low/High Blood Pressure*	*__Scoliosis*
__Cancer	*__Joint replacement(s)*	*__Sinus problems*
__Carpal Tunnel Syndrome	*__Mechanical implants*	*__Skin disorders*
__Chronic pain	*(pacemaker, insulin pump, etc.)*	*__Stroke*
__Circulatory conditions	*__Metal in the body*	*__Sprain/strain*
__Cold/ Flu	*(pins, plates, screws, etc.)*	*__Spider veins*
__Diabetes	*__Neuropathy*	*__TMJD*
__Epilepsy	*__Numbness*	*__Varicose veins*

ANY OTHER MEDICAL CONDITIONS TO BE AWARE OF? _____

MASSAGE INFORMATION

Ever received professional massage therapy? __yes __no How recently _____ Frequency _____ Have you ever received cupping therapy? Y / N

If yes, from: __ Licensed Massage Therapist __ Acupuncturist __ other

What kind of pressure do you like? (Light, medium, firm, deep, in between) _____

Areas to FOCUS on during massage? _____

Areas to AVOID (areas you may not like to be worked like face, feet, etc.)? _____

Goals for treatment? _____ *Any allergies to oils, nuts, or lotions? __yes __no If so, what kind?* _____

PLEASE INITIAL EACH ITEM BELOW:

__ I have listed all my known medical conditions and physical limitations __ I will inform my massage therapist of any changes in my physical health.

__ I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and/or improving circulation.

__ I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

__ I am responsible for consulting my physician for any physical element that I have.

__ I am aware that I am financially responsible for my treatments at the time of appointment, unless prior arrangements have been made.

__ If at any time during the appointment I would like pressure, music, room temperature or anything else adjusted, I will inform the therapist.

__ I understand that cupping marks may result from any cupping treatment due to the release of any old stagnation and/or toxicity within the tissue.

__ I also understand that if I fail to give 24 hours' notice of canceling an appointment, that I will be responsible for designated cancellation fee, unless in the event of emergency.

CLIENT SIGNATURE: _____ DATE: _____