

## Body & Sole Therapy

### Client Intake Form

#### Client Contact Information

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M F Referred By: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Massage Information

1. Have you ever received professional massage/bodywork before? Yes No

2. How recently/how often? \_\_\_\_\_

3. What kind of pressure do you prefer? Light Medium Firm

4. AVOID these areas:

Face Head Neck Arms Shoulders Abdominals Back Glutes Legs Feet

5. Is this massage/bodywork medically necessary (Is it for a medical condition, injury, surgery)? Yes No

If yes, do you have a physician's referral/prescription? Yes No

6. List your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

\_\_\_\_\_

7. Do these symptoms interfere with your activities of daily living (sleep, exercise, work, etc.)? Yes No

Explain:

\_\_\_\_\_

8. List the medications you currently take (prescribed and over the counter):

\_\_\_\_\_

9. Are you pregnant? Yes No If yes, due date? \_\_\_\_\_

10. Are you wearing a hairpiece? Yes No

11. Are you wearing contacts? Yes No

12. Are you wearing dentures? Yes No

#### Health History

1. Please list any surgeries or injuries in the past that may influence massage:

\_\_\_\_\_

2. Circle any of the following health conditions that you currently have:

Blood clots Infections Congestive heart failure Contagious disease Pitted edema

*Please answer honestly, as massage may not be indicated for the above conditions.*

3. Please indicate conditions that you have or had in the past. Explain, in detail, including treatment received.

Current Past Muscle or joint pain \_\_\_\_\_

Current Past Numbness or tingling \_\_\_\_\_

Current Past Swelling \_\_\_\_\_

Current Past Bruise easily \_\_\_\_\_

Current Past Sensitive to touch/pressure \_\_\_\_\_

Current Past High/low blood pressure \_\_\_\_\_

Current Past Stroke, heart attack \_\_\_\_\_

Current Past Shortness of breath \_\_\_\_\_

Current Past Cancer \_\_\_\_\_

Current Past Neurological (e.g. MS, Parkinson's) \_\_\_\_\_

Current Past Epilepsy, seizures \_\_\_\_\_

Current Past Headaches, migraines \_\_\_\_\_

Current Past Dizziness, ringing in the ears \_\_\_\_\_

Current Past Digestive conditions (e.g. Crohn's, IBS) \_\_\_\_\_

Current Past Arthritis (rheumatoid, osteoarthritis, gout) \_\_\_\_\_

Current Past Osteoporosis, degenerative spine/disk \_\_\_\_\_

Current Past Allergies \_\_\_\_\_

Current Past Diabetes \_\_\_\_\_

Current Past Endocrine/thyroid conditions \_\_\_\_\_

Current Past Depression/anxiety \_\_\_\_\_

Current Past Memory loss, confusion, easily overwhelmed \_\_\_\_\_

Current Past Chronic Pain \_\_\_\_\_

#### Consent for Treatment

If I experience any discomfort during the session, I will immediately inform the practitioner so that they may adjust their pressure to my comfort level. I further understand that the massage and body work professional should not be construed as a substitute for a medical examination, diagnosis, or treatment where I should be seeing a physician, or other medical specialist. I understand that body work practitioners are not qualified to perform spinal or skeletal adjustments, to diagnose or treat any physical or mental illness. Because massage and body work should not be performed under certain medical conditions, I affirm that I have stated all my medical conditions and answered all the questions honestly, I agree to keep the practitioner updated on any changes to my medical profile and there is no liability on the practitioner's part if I fail to do so. I also understand that illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session and I am still liable for payment to the practitioner for the scheduled appointment. I understand all of this and give my consent to receive this care. **I am also aware that I will be charged the FULL price of my session if I cancel an appointment with less than a 24-hour notice or no show my appointment.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature (in case of a minor) \_\_\_\_\_ Date: \_\_\_\_\_