

# INTAKE FORM

Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Day \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_

Age \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ M\_\_ F\_\_ Occupation \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Have you had massage therapy before? \_\_\_\_\_

What is your major area of pain or concern? \_\_\_\_\_

When did you first notice it? \_\_\_\_\_ What have you done to get relief? \_\_\_\_\_

Has there been a medical diagnosis? \_\_\_\_\_

## PAST HISTORY

Have you ever had a similar problem before? \_\_\_\_ When? \_\_\_\_ What caused those episodes? \_\_\_\_\_

Are you presently under a doctor's care? \_\_\_\_\_

\_\_\_\_ Name of physician / chiropractor \_\_\_\_\_ Ph # \_\_\_\_\_

Previous operations \_\_\_\_\_

Previous broken bones \_\_\_\_\_

Previous accidents or injuries \_\_\_\_\_

**CIRCLE** any **CURRENT** conditions. **Underline** any you have had as **PAST** problem.

- |                            |                                    |                           |
|----------------------------|------------------------------------|---------------------------|
| Headaches                  | Muscles spasms in neck             | Cold sweats               |
| Shooting pains in head     | Grinding in neck                   | Liver trouble             |
| Sinus trouble              | Tightness in shoulder muscles      | Gallbladder trouble       |
| Loss of smell              | Neuritis in shoulders and arms     | Indigestion               |
| Loss of taste              | Pins and needles in arms and hands | Intestinal gas            |
| Tightness in throat        | Cold hands                         | Constipation              |
| Inflammation of throat     | Chest pains                        | Kidney trouble            |
| Thyroid trouble            | Shortness of breath                | Bladder trouble           |
| Face flushed               | T.B.                               | Diabetes                  |
| Twitching of face          | Heart pain                         | Cancer                    |
| Loss of memory             | Heart palpitations                 | Sleeping problems         |
| Fatigue                    | Heart attack                       | Painful joints            |
| Depression                 | High blood pressure                | Swollen joints            |
| Head feels too heavy       | Low blood pressure                 | Arthritis                 |
| Dizziness                  | Anemia                             | Herniated or bulging disk |
| Fainting                   | Blood clots, phlebitis             | Pinched nerves in back    |
| Loss of balance            | Pins and needles in legs           | Ringing in ears           |
| Rheumatic fever            | Swollen ankles                     | Nervous stomach           |
| Cold feet                  | Light bothers eyes                 | Stomach trouble           |
| Pains in legs and feet     | Ulcers                             | Sciatica                  |
| Asthma                     | Nervousness                        | Numb hands or feet        |
| Epilepsy or other seizures | Inner tension                      | Varicose veins            |
| Skin disorders             | Other _____                        |                           |

Your therapist has zero tolerance for sexually inappropriate behavior. If you (the client), feel uncomfortable, at any time during the session, of the placement of their hands, please let your therapist know. Any action deemed sexually illicit will terminate the session.

1. Signature \_\_\_\_\_ Date \_\_\_\_\_