



Elements to Wellness

Massage & Skin

Client Intake Form

Date: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Daytime Phone #: _____ Evening Phone #: _____
Cell Phone #: _____
Email Address: _____ @ _____
Date of Birth: _____
Occupation: _____

How did you hear of us _____
Referred by _____

Primary Health Care Provider: _____
Provider's Address: _____
City: _____ State: _____ Zip: _____
Telephone #: _____ Extension: _____

Permission to Consult with Primary Provider? No Yes _____ (please initial if yes)

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____
Relationship: _____

Medications: _____

On the next page, Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Please use back of form to explain all checked conditions Client initials _____



Elements to Wellness

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Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, Neck, Arm pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: _____

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: _____

Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: _____

Reproductive System

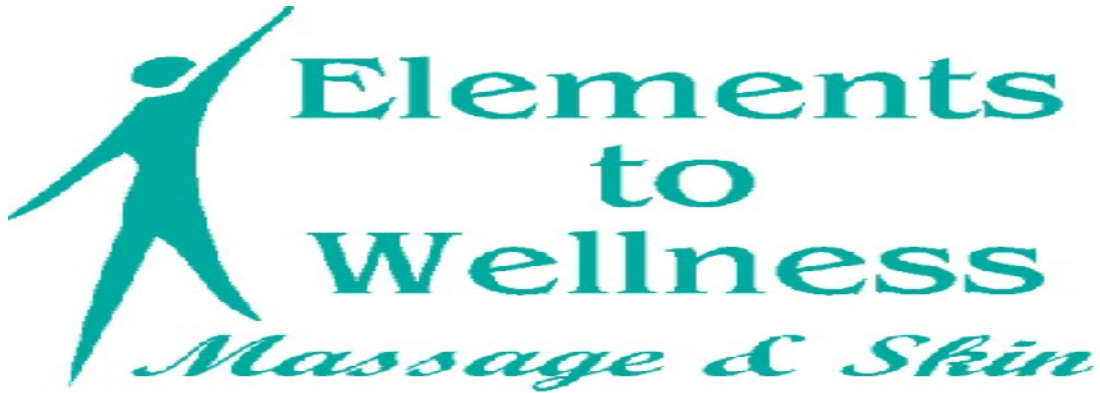
- Pregnancy:
- Current
- Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use _____
- Alcohol use _____
- Nicotine use _____
- Caffeine use _____
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list)

- Other congenital or acquired disabilities (please list)

- Surgeries _____
- Other: _____



Massage Therapy Informed Consent

I, _____, (client) understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

Client Signature _____ Date _____

Policies:

Cancellations:

Your business is valued and your cooperation is appreciated .We are making a commitment to you to guarantee your appointment time and refusing all other requests once you have made the appointment. A 24-hour cancellation notice is required for any scheduled appointments including gift certificate sessions. Missed or no-show appointments will result in your being charged the full amount of the session. Depending on our booking schedule, late appointments may not receive the full session time allotted for the treatment service booked: Full payment is required.. Emergency cancellations are determined by the Massage Therapist discretion.

Client Signature _____ Date _____