Client Intake Form for Beside Still Waters Massage

Personal Information:

Name_____ Date of Birth_____

Address_____City/State/Zip_____

Phone (Cell)_____Phone (Home)_____

Occupation_____Email_____

Emergency Contact_____Phone_____

The following information will be used to help plan a safe and effective massage session. Please answer the questions to the best of your knowledge

1. Who can we thank for referring you to Beside Still Waters? _____
2. Have you had a professional massage before? Yes No
   If yes, how often do you receive a massage?_____
3. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please describe_____
4. Do you have any allergies or sensitivities to oils, lotions, scents, or ointments? Yes No
   If yes, please describe_____
5. Do you have sensitive skin? Yes No
6. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?
7. Do you sit for long hours at a workplace, computer, or driving? Yes No
   If yes, please describe_____
8. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe_____
9. Do you experience stress in your work, family, or other aspect of your life? Yes No
   If yes, what do you do to relieve the stress?_____
10. Is there a particular area of the body where you are experiencing tension, stiffness, pain, numbness, or other discomfort? Yes No
    If yes, please describe_____
11. Is your condition the result of an accident or injury? Yes No
    If yes, please describe and date_____
12. Do you have any particular goals in mind for your massage sessions? Yes No
    If yes, please describe_____
13. On a scale of 1 – 10 (10 being the highest) what is your level of pain or discomfort?_____
    What seems to help the most?_____

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14. Are you currently under medical supervision? Yes No

    If yes, please explain_____

15. Do you see a chiropractor? Yes No If yes, how often?_____

16. Are you currently taking any over the counter or prescription medication? Yes No

    If yes, please list_____

17. Do you take any supplements, herbs, or homeopathic remedies? Yes No

    If yes, please list_____

18. Please check any conditions you have currently (C) or in the past (P) and explain if necessary

( ) Contagious skin condition
( ) Open sores, wounds, rash
( ) Bruise easily
( ) Fractures
( ) Heart condition
( ) Vascular problems
( ) Blood Clot / DVT / Aneurysm
( ) Artificial joint
( ) High or low blood pressure
( ) Edema
( ) Breathing Problems / Asthma
( ) Sinus / TMJ
( ) Circulatory disorder
( ) Varicose veins
( ) Phlebitis
( ) Athlete's Foot / Warts
( ) Sprains / Strains
( ) Arthritis_____
( ) Osteoporosis
( ) Epilepsy
( ) Headaches / Migraines
( ) Cancer
( ) Diabetes
( ) Fibromyalgia
( ) Back / Neck problems
( ) Hip / Leg problems
( ) Decreased sensation
( ) Carpal tunnel syndrome
( ) Dizziness / Vertigo
( ) Insomnia / Sleep disorders
( ) Chronic pain / Inflammation
( ) Depression / psychological issue
( ) Golf / Tennis elbow
( ) Pregnancy If yes, how far along?
( ) Nausea / Vomiting
( ) Anxiety
( ) Gastrointestinal issues
( ) Tremors / twitches

19. Is there anything else about your health history the you think would be useful to know to plan a safe and effective massage routine for you?_____

    _____

I have stated all conditions that I am aware of and this information is accurate to the best of my knowledge. I will inform BSW if anything changes in my status as treatment continues.

Client Signature_____ Date_____