Whole Life Center for Health

Massage Client Intake Form

◦personal information◦

name ______ date of birth ______

address ______

city ______ state ______ zip ______

home phone ______ cell phone ______

email ______

occupation ______ employer ______

marital status ______ spouse's name ______

emergency contact/phone number ______

physician's name/ phone number ______

referred by ______

◦massage experience◦

Have you had a professional massage before? ___yes ___no

If yes, what types of massage (Swedish, shiatsu, etc.)?

______

How long have you been receiving massage therapy?

______

Frequency of massages? ______

What are your goals for treatment? ______

◦current health◦

Have you recently had an injury, surgery, or areas of inflammation?
__yes __no

If yes, describe______

Do you have sensitive skin? __yes __no

Do you have any allergies to oils, lotions, or ointments? ___yes __no

If yes, please explain______

List any medications that you are currently taking______

List any known allergies______

Do you have any allergies to nuts or peanuts? __yes __no

◦health history◦

Musculoskeletal
__Bone or joint disease
__Tendonitis/Bursitis
__Arthritis/Gout
__Jaw Pain (TMJ)
__Lupus
__Spinal Problems
__Migraines/Headaches
__Osteoporosis

Circulatory
__Heart Condition
__Phlebitis/Varicose Veins
__Blood Clots
__High/Low Blood Pressure
__Lymphedema
__Thrombosis/Embolism

Skin
__Allergies, specify: ______
__Rashes
__Cosmetic Surgery
__Athlete's Foot
__Herpes/Cold Sores

Digestive
__Irritable Bowel Syndrome
__Bladder/Kidney Ailment
__Colitis
__Chrohn's Disease
__Ulcers

Psychological
__Anxiety/Stress Syndrome
__Depression

Respiratory
__Breathing Difficulty/ Asthma
__Emphysema
__Allergies,specify: ______
__Sinus Problems

Nervous System
__Shingles
__Numbness/Tingling
__Pinched Nerve
__Chronic Pain
__Paralysis
__Multiple Sclerosis
__Parkinson's Disease

Reproductive
__Pregnant, stage______
__Ovarian/Menstrual Problems
__Prostate

Other
__Cancer/ Tumors
__Diabetes
__Drug/Alcohol/Tobacco Use
__Contact Lenses
__Dentures
__Hearing Aids

Any other medical condition(s) not listed:______

Please explain any of the conditions that you have marked above: ______

◦client agreement◦

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all of my medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

______
Signature date

______
name (please print)

Please read and complete the Cranial Sacral Therapy section only if it applies to you.

If you would like to learn about Cranial Sacral Therapy and its benefits, please ask us, we would be happy to help!

◦contraindications of Cranial Sacral Therapy◦

absolute contraindications:

__acute inflammation in the body
__severe or open head wounds
__skull fractures
__recent heart attack
__recent stroke
__infection whose course is unclarified
__brain tumor
__cerebral edema
__hematoma
__cerebral hemorrhage
__cerebral aneurysm
__uncontrolled high blood pressure

precautions:

__acute, severe pain
__recent concussion
__fresh injuries to head, spine, or sacrum
__whiplash
__epilepsy
__auto-immune disorder
__disease & disorder affecting the nervous system
__Schizophrenia, severe psychological illness
__osteoporosis
__recent severe fall, accident, or operation

◦client agreement◦

It is my choice to receive Cranial Sacral Therapy (CST). I am aware of the benefits and risks of CST and give my consent for CST. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that CST is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature ____________________ Date

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Preferred Contact Information Form

Name: ______________________________ **DOB:** __________________

Preferred Phone Number: (____) ______________________

Preferred Method of Appointment Reminders: Calls *or* Texts (circle preference)

E-mail Address for Office Newsletter: ____________________@__________________.______

____
Patient's Signature

____
Date