WELLNESS SERVICES CLIENT INTAKE FORM

NAME: _____ Date of Birth: ____/____/____

ADDRESS: _____

PHONE NUMBERS: Home: _____ Cell: _____ Email: _____

REFERRED BY: _____ Occupation:_____ Date: ____ /____/___

EMERGENCY CONTACT: _____

If currently in treatment: Physician (name and location):

_____

If client is under the age of 18 years or unable to decide for themselves, the parent or guardian for the client is giving informed consent for the client to receive massage by printing and signing name below.

Please print name, sign and date:

_____

Please review the following list of conditions and check anything that might be relevant to you:

___Allergies (including oils, nuts, fragrances)

___Broken bones

___Cancer

___Chronic Pain

___Diabetes

___ Fibromyalgia

___ Headache

___ Skin condition

___ Pregnancy

___ Scoliosis

___ Varicose Veins

___ Carpal Tunnel Syndrome

___Back pain: __upper __ mid __ lower

___Cardiac/circulatory condition low blood pressure

___Arthritis __ Rheumatoid __ Osteoporosis

___ Decreased range of motion

___Herniated Disc

___Numbness

___Seizures

___ Current injury or illness

___ Muscle strain / sprain

___ Unexplained discomfort or pain

___ Whiplash

___ Other

Please continue on other side

Have you recently had an injury, surgery or areas of inflammation? If yes, please describe:

_____

_____

If you are currently being treated by a health care professional, please state why:

_____

_____

Are you currently taking any medications? (including aspirin, ibuprofen or homeopathic remedies):

_____

_____

Do you exercise regularly and /or participate in any sports? If yes, what type and how frequently?

_____

_____

What particular goals do you have for your therapy?

_____

_____