CLIENT INTAKE FORM

Name _____Phone _____DOB _____Gender _____
Address _____City _____State _____Zip _____
E-mail _____Occupation _____ Referred by _____
Emergency contact _____Phone _____

Have you ever received professional massage/bodywork before? _____ How recently? _____
What are your goals/expected outcomes for receiving massage/bodywork? _____

How do you feel today? _____ Do any of the symptoms you have interfere with your activities of normal daily living? _____If so please explain _____

Are you wearing contacts? _____ Are you wearing a hairpiece?_____
Are you pregnant?_____ Are you wearing dentures? _____

Circle any of the following health conditions that you currently have. (If you are unsure, please ask):
Blood clots, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received.

Current Past High blood pressure - If current – Is it under control? _____

Current	Past	Muscle or joint pain	Current	Past	Dizziness, ringing in the ears
Current	Past	Muscle or joint stiffness	Current	Past	Digestive conditions (e.g. Crohn'
Current	Past	Numbness or tingling	Current	Past	Gas, bloating, constipation
Current	Past	Swelling	Current	Past	Kidney disease, infection
Current	Past	Bruise easily	Current	Past	Arthritis (rheumatoid, osteoarthritis)
Current	Past	Sensitive to touch/pressure	Current	Past	Osteoporosis, degenerative spine/disk
Current	Past	Stroke, heart attack	Current	Past	Scoliosis
Current	Past	Varicose veins	Current	Past	Broken bones
Current	Past	Shortness of breath, asthma	Current	Past	Allergies
Current	Past	Cancer	Current	Past	Diabetes
Current	Past	Neurological (e.g.MS, Parkinson's, chronic pain)	Current	Past	Endocrine/thyroid conditions
Current	Past	Epilepsy, seizures	Current	Past	Depression, anxiety
Current	Past	Headaches/ migraines	Current	Past	Memory loss, confusion

What surgeries or injuries have you had? _____
What other scars do you have? _____
List medications you are currently taking _____

Consent for Treatment:

I give Bruce Beery permission to provide treatment that will include "hands-on" manual therapy and instructions for my own therapeutic exercise. I understand that I am an active participant in my healing and it is my responsibility to provide accurate and timely feedback to Bruce regarding my response to treatment. If I experience pain or discomfort during the session I will immediately inform Bruce so the techniques can be adjusted to my level of comfort. I may become aware of memories and/or emotions as a result of treatment and I am free to express them as part of my healing process. I may experience pain and/or soreness after my treatment. I understand that this is part of my healing process. I can choose to stop the treatment completely for any reason, at any time, if I so choose. I affirm that I have informed Bruce of all my known medical conditions and will keep him updated as to changes in my medical condition. Bruce does not diagnose any physical or psychological disorders and nothing said or done by him should be misconstrued as such. Nor does Bruce prescribe medication or perform spinal manipulations. I am responsible for consulting a qualified physician for any physical and/or psychological ailments that I may have. I understand that Bruce's work should not be a substitute for this care.

Client signature: _____ Date:_____