



# *Soothing Therapeutics*

## **Client Intake Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alt Phone # \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Appt Day/Time: \_\_\_\_\_ Referred By: \_\_\_\_\_

What are your goals in receiving massage?

What are the repetitive postures/motions that you perform at work/other setting?

What are your exercise activities?

Please list any current medications and their purposes:

### **Massage Informed Consent and Agreement**

It is my choice to receive massage, and I understand that the session is intended for relaxation, muscle tension release, increased range of motion, improved circulation, reduced stress, increased energy flow and balance, and a positive opening experience. I understand that massage is not a substitute for medical treatment, examination, or medications, and that it is recommended to concurrently work with my primary caregiver for any condition that I may have. I have informed the massage practitioner of all my known physical and medical conditions and medications, and I will keep her updated to any changes in my health status. I understand that all information regarding my health history, the records of my sessions, and other personal information related to the session will remain in complete confidence. If this information is requested, I will release it under written consent. I will follow the **24-hour cancellation policy** via phone, or I will need to pay the full amount for the massage (unless it is an emergency situation). Please be on time. Thank you.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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## **Health History**

Please check all that apply to you

(Specify whether currently or previously)

### **Muscular-Skeletal**

- Headaches
- Joint stiffness/swelling
- Broken/Fractured Bones
- Strains/Sprains
- TMJ Dysfunction
- Tendonitis
- Bursitis
- Sciatica
- Arthritis
- Osteoporosis
- Scoliosis
- Shoulder dislocation
- Whiplash
- Knee surgery
- Hip replacement
- Other \_\_\_\_\_

### **Nervous System**

- Numbness/Tingling
- Sleep disorders
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue
- Parkinson's Disease
- Carpal Tunnel Syndrome
- Spinal cord injury
- Thoracic Outlet Syndrome
- Disc Herniation
- Other \_\_\_\_\_

### **Circulatory/Respiratory**

- Dizziness/Fainting
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Asthma
- Low/High blood pressure
- Other \_\_\_\_\_

### **Digestive**

- Diverticulosis
- Irritable Bowel Syndrome
- Crohn's Disease
- Colitis
- Adaptive Aids
- Diabetes
- Other \_\_\_\_\_

### **Other**

- HIV
- Fibromyalgia
- Hearing impaired
- Visually impaired
- Surgeries \_\_\_\_\_
- Drug use \_\_\_\_\_
- Infectious disease \_\_\_\_\_
- Depression \_\_\_\_\_
- Other \_\_\_\_\_

### **Reproductive**

- Pregnancy
- Menopause
- Fibroids
- Endometriosis
- PCOS
- Hysterectomy
- Cesarean Section
- Irregular or Painful Menses
- Miscarriage
- Fertility Treatments \_\_\_\_\_
- Other \_\_\_\_\_

The information provided above is accurate to the best of my knowledge.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_