

# Muscles In Mind Confidential Client Intake Form

Please turn off or silence your cell phone

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

email \_\_\_\_\_ Initial here if I may send special offers/cards \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer/Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_ Usual activity level low medium high

What is your energy level recently? low medium high What is your stress level? low medium high

How does stress affect your health? anxiety insomnia irritability muscle tension indigestion

other \_\_\_\_\_

List stress reduction activities & frequency \_\_\_\_\_

Have you received therapeutic massage or bodywork before? Yes No \_\_\_\_\_

What kind? \_\_\_\_\_ How often? \_\_\_\_\_ Preferred pressure \_\_\_\_\_

Date of last massage \_\_\_\_\_ What did you like/dislike about it? \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

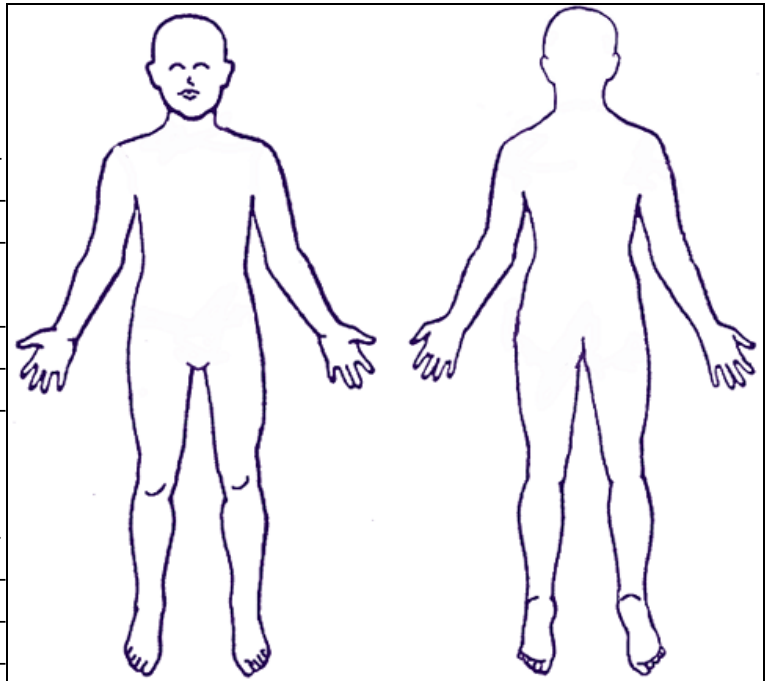
What are your goals for today's session? \_\_\_\_\_

Is there a particular area of your body where you experience tension, stiffness, pain, or other discomfort? \_\_\_\_\_  
explain \_\_\_\_\_

Is there any area you do not want worked on?  
Like recent injection site, medication patch,  
open wound, numb area, rash, bruise, inflamed  
joint or other issue... \_\_\_\_\_

Do you have allergies or sensitivities? Yes No \_\_\_\_\_

Is there anything else the practitioner should  
know in order to give a safe & effective  
massage: \_\_\_\_\_



For my convenience, please be aware of:

contacts hearing aid(s) hairpiece/hair extensions denture \_\_\_\_\_

## Medical Information

Are you pregnant? Yes No How far along? \_\_\_\_Weeks Due Date \_\_\_/\_\_\_/\_\_\_ Restrictions? \_\_\_\_\_

Please list past/current conditions illnesses injuries surgeries hospitalizations (within 5 years)

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<input type="checkbox"/> circulatory/blood _____	<input type="checkbox"/> skin _____
<input type="checkbox"/> bone/joints _____	<input type="checkbox"/> autoimmune _____
<input type="checkbox"/> respiratory/breathing/asthma/sinus problems _____	<input type="checkbox"/> viral _____
<input type="checkbox"/> digestive _____	<input type="checkbox"/> liver/kidney _____
<input type="checkbox"/> muscular _____	<input type="checkbox"/> emotional _____

Are you currently under the care of a physician? \_\_\_\_\_ If yes, please list names & reason/treatment:

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List any supplement, over the counter medication, or prescription you are taking, with the reason:

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Are you experiencing any side effects? \_\_\_\_\_

Because massage is very beneficial for certain conditions, and should not be performed under other medical conditions, I affirm that I have informed the therapist of all known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes. There shall be no liability on the therapist's part due to my forgetting to relay pertinent information.

I have completed this health form to the best of my knowledge. I understand that Massage Therapy and Bodywork services are a therapeutic health aid and are non-sexual. Any illicit remarks or advances made by me will result in the termination of the session, and I will be liable for full payment of the scheduled appointment. Massage and Bodywork do not take the place of a physician's care when indicated. The therapist does not diagnose or treat any physical or mental illness, prescribe medication, or perform spinal manipulations. Nothing during the session should be construed as such. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide me with the best health care services. I understand that the massage I receive is for the basic purpose of relaxation and relief of muscular tension or stress. If I experience pain or discomfort during the session, I will immediately communicate that to the therapist so that treatment may be adjusted, if necessary.

Client signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Practitioner signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Consent for treatment of minor: By my signature below I authorize \_\_\_\_\_ to administer massage therapy for my child or dependent \_\_\_\_\_ as is deemed necessary.

Parental or Guardian Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_