Branches of Wellness *Therapeutic Massage & Bodywork* ~ *4f Kellogg Rd* ~ *Essex Jct, VT 05452* ~ *802-922-7946*

CLIENT INTAKE INFORMATION FORM

Name: _____ Date: _____

Address: _____City: _____ State _____ Zip: _____

Phone: _____Cell: _____ Work: _____

Email: _____ Date of Birth: _____

Occupation: _____ Employer: _____

Referred by: _____ Reason: _____

Physician: _____ Date of Last Physical: _____

Please list current medications, including aspirin, ibuprofen, herbs, supplements and reason for medication: _____

_____

_____

Emergency contact-Name and number: _____

Primary reason for appointment/areas or tension: _____

_____

Previous experience with massage: _____

What is your reason for choosing massage and what results do you expect from this treatment? _____

_____

Please list all forms and frequency of stress reduction activities, hobbies, exercise, or sports participation: _____

_____

Surgeries: _____

Accidents: _____

Please mark an (X) for all conditions that apply now. Put a (P) for past conditions, and (F) for family history of illness. For current conditions on the right hand side numerically label using a PAIN SCALE of 1-10 with 1 minor to 10 severe.

__ Abdominal or digestive problems
__ Allergies _____
__ Arthritis, tendonitis
__ Anemia
__ Anxiety
__ Asthma or lung condition
__ Birth control, IUD
__ Bleeding/bruising/blood clots
__ Bursitis
__Cancer, tumors
__Cardiac issues
__Chronic Fatigue/Fibromyalgia
__ Chronic Pain
__ Circulation Problem
__ Cold Sweats
__ Constipation, diarrhea
__ Contact lens, vision problem
__ Contagious, infectious diseases
__ Dental bridges, braces
__ Depression
__ Diabetes
__ Dizziness, fainting
__ Endocrine Issues
__ Fatigue
__ Headaches, migraines
__ Hearing problems, deafness
__ Hernia
__ High/low blood pressure
__ Injuries to face or head
__ Jaw pain, TMJ problems
__ Joint pain
__ Kidney/urinary problems
__ Liver/gall bladder problems
__ Muscle strain/sprain
__ Muscle, bone injuries
__ Neuritis
__ Numbness or tingling
__ Osteoporosis
__ Pins/pacemaker
__ Pregnant
__ Psychiatric
__ Recent surgery/trauma
__ Seizures/epilepsy
__ Sinus problems
__ Skin conditions
__ Sleep difficulties
__ Smoker
__ Spinal column disorders
__ Stress, tension
__ Ulcers
__ Varicose veins
__ other medical conditions

Explain any areas noted above:_____
_____
_____

Surgeries: _____
Accidents: _____
Any other conditions, syndromes or anything else pertinent to your health status: _____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical conditions and shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature _____ Date _____