CLIENT INTAKE

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TRUE NORTH MASSAGE

A. Client information

Name: _____ Birth date: _____

Address: _____ Occupation: _____

Phone: _____ Ok to leave message? _____

Email: _____ Join our e-mail list: Yes ☐ No ☐

Emergency contact: _____ *Phone:* _____

B. Health history: *Mark any conditions you've experienced in the past 5 years, as well as any others currently affecting you*

General: headaches/migraines; sleep disturbances; fatigue; accidents; injuries; surgery; infectious condition; concussions

Muscles & joints: torn muscle; sprains/strains; osteoarthritis; rheumatoid arthritis; scoliosis; osteoporosis; easily dislocated joints; joint replacement; joint noise/popping; TMJ; disk problems; broken bones; muscle pain/stiffness; joint pain/stiffness

Cardiovascular: heart condition; high/low blood pressure; atherosclerosis; blood clots; hemophilia; poor circulation; varicose veins; chest pain during exertion; lymphaedema; phlebitis

Nervous: numbness/tingling; sciatica; shooting pain; dizziness, ringing in ears; loss of memory, confusion; depression

Respiratory: asthma; nose and throat problems; chronic sinus issues; chronic nosebleeds

Digestive: acid reflux; ulcers; constipation; diarrhea; gall stones; pancreatitis; gas, bloating

Endocrine: thyroid; parathyroid; pituitary (hyperactive or hypoactive); diabetes

Urinary/Reproductive: kidney stones; renal failure; UTI; IUD; currently pregnant, bladder control; loss of pelvic sensation

Skin: rashes; psoriasis; shingles; warts; fungus

Other: cancer; tumors; epilepsy; lymphatic

Please describe any conditions marked above, including dates, treatment, and current status (resolved, chronic, etc).

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C. Other health information

Please list medications taken in the past 6 months, including reason(s) for taking:

Are you currently under the care of other health care providers? _____

What kind of provider(s)? (MD, LMT, ND, LAc, DC, etc.) _____

Reason why: _____

D. Lifestyle information

Describe your typical day (activities):

Mark the activities affected by health condition / All of the above	Mark other activities affected: sleep | washing | dressing | fitness

How do you reduce stress? Pain?

Have you received massage before? Yes No	Date of last session:

Reason for last session:	What was the outcome?

What are your goals for receiving massage?

Mark the areas you are **comfortable** receiving massage:

☐ upper chest ☐ abdomen ☐ arms ☐ hands ☐ face ☐ scalp ☐ neck ☐ back ☐ legs ☐ feet ☐ glutes ☐ thighs

Additional comments:

E. Contract and consent for care

I agree to participate fully in my health care. I will make sound choices regarding my treatment plan based on the information provided by my massage therapist and my experience of those suggestions. I agree to participate in the self-care program we agree upon. I promise to inform my practitioner any time I feel my wellbeing is threatened or compromised. I expect my massage therapist to provide safe and effective treatment.

I have provided all my known medical information and will inform my practitioner of any changes in my health. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I give my consent to receive massage.

Signature: _____ Date: _____