

# BODY & SOUL RETREAT

## MASSAGE CLIENT INTAKE & CONSENT FORM



### **Contact Information: Please read and complete both sides of this form.**

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ( ) Male ( ) Female

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_ Referred By: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

### **Medical Background: Please read and complete both sides of this form.**

Is this your first professional massage? \_\_\_\_\_ If no, how frequently do you receive a massage? \_\_\_\_\_

What do you hope to accomplish from today's massage? \_\_\_\_\_

Are you aware of any tension holding spots in your body? \_\_\_\_\_ If yes, location(s) \_\_\_\_\_

Describe any surgeries, hospitalizations, accidents, or injuries you've had:

Less than 5 years ago: \_\_\_\_\_

More than 5 years ago: \_\_\_\_\_

Do you feel that you have recovered from these events? \_\_\_\_\_ Please explain: \_\_\_\_\_

Do you have any chronic, ongoing pain that you deal with on a regular basis? \_\_\_\_\_

Please explain: \_\_\_\_\_

Describe what activities cause this pain and/or make it worse: \_\_\_\_\_

Are you receiving any other type of medical treatment? \_\_\_\_\_ Please explain: \_\_\_\_\_

Please list any medications (vitamins, herbs, or pharmaceutical) taken now or at regular intervals (including of what Medication is used to treat): \_\_\_\_\_

Are you currently under the care of a physician? \_\_\_\_\_ Please list reason(s): \_\_\_\_\_

Are there any other health concerns you wish to discuss today? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

**Please read and complete both sides of this form.**

# Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

## Musculoskeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendinitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: \_\_\_\_\_

## Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: \_\_\_\_\_

## Skin

- Rashes
- Allergies
- Athletes Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: \_\_\_\_\_

## Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: \_\_\_\_\_

## Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: \_\_\_\_\_

## Reproductive System

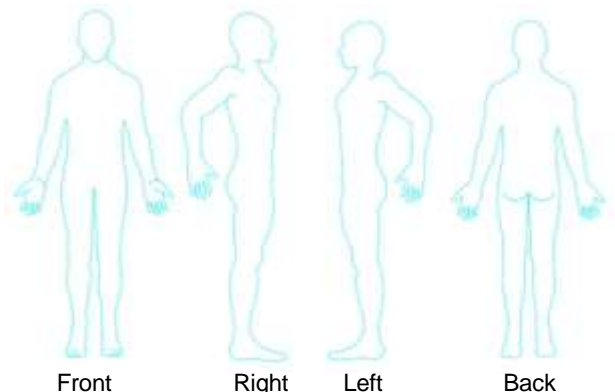
- Pregnancy:
  - Current
  - Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

## Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use \_\_\_\_\_
- Alcohol use \_\_\_\_\_
- Nicotine use \_\_\_\_\_
- Caffeine use \_\_\_\_\_
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list) \_\_\_\_\_
- Other congenital or acquired disabilities (please list) \_\_\_\_\_
- Surgeries \_\_\_\_\_
- Other: \_\_\_\_\_

For clients who need mobility assistance, please give your Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please indicate where you experience pain on the diagram below.



The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. Clients Under the age of 18 must obtain Parental/Guardian consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parental/Guardian Consent) Signature: \_\_\_\_\_ Date: \_\_\_\_\_