Balance Your Life

Client Intake Form

FOR OFFICE USE:

Client Name ____________________

Client Reference Number ____________________

Date of First Visit ____________________

Personal Information

Name ____________________ DOB ___/___/___ Occupation ____________________

Address ____________________ Phone (Mobile) ____________________

Email ____________________ Primary Physician ____________________

Emergency Contact ____________________ Relationship ______________ Phone ______________

Medical Information

Are you taking any medications? ☐Yes ☐No

If yes, please list name and use: ____________________

____

Are you currently pregnant? ☐Yes ☐No

If yes, how far along? ____________________

Any high risk factors? ____________________

Do you suffer from chronic pain? ☐Yes ☐No

If yes, please explain ____________________

What makes it better? ____________________

____

What makes it worse? ____________________

____

Have you had any orthopedic injuries? ☐Yes ☐No

If yes, please list: ____________________

____

Please indicate any condition you have had in the past or currently have:

☐ Cancer
☐ Headaches/migraines
☐ Arthritis
☐ Diabetes
☐ Joint replacement(s)
☐ High/low blood pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart attack
☐ Kidney dysfunction
☐ Blood clots
☐ Numbness
☐ Sprains or strains

Explain any conditions you have marked above: __________

____

____

What sport or physical activity do you enjoy doing : ________

____

Massage Information

Have you had a professional massage before? ☐Yes ☐No

What type of massage are you seeking?

☐Relaxation ☐Therapeutic/Deep Tissue ☐Other ___________

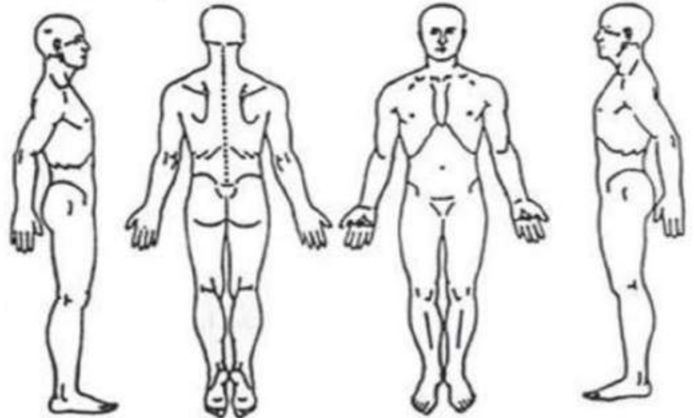
What pressure do you prefer? ☐Light ☐Medium ☐Deep

Are you sensitive to any fragrances? ☐Yes ☐No

Are there any areas (eg feet, face, abdomen) you do not want massaged? ☐Yes ☐No Any reason? ____________________

What are your goals for this treatment session? ______________

Please circle any areas of discomfort:



Consent for Treatment

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/bodywork should not be construed as a substitute 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 profile and understand that there 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. Understanding all of this, I give my consent to receive care.

Client Signature: ____________________ Date: ___/___/___

Parent/Guardian Signature: ________________ Date: ___/___/___