CLIENT INTAKE AND MEDICAL HISTORY FORM

CHECK THE LOCATION THAT YOU WISH TO VISIT: ☐ **LOS ALTOS** ☐ **PLEASANTON**

NAME: DATE:

ADDRESS: CITY: STATE: ZIP:

PREFERRED PHONE NUMBER: EMAIL:

BIRTH DATE: OCCUPATION:

EMERGENCY CONTACT: PHONE:

HOW DID YOU HEAR ABOUT US? ARE YOU REDEEMING A GIFT CARD / PACKAGE?

Please take a moment to carefully read the following information. If you have a specific medical condition or specific symptoms, Bodywork / Massage may be contraindicated. A referral from your Primary Care Provider may be required prior to any services being rendered.

HAVE YOU EVER RECEIVED THERAPEUTIC BODYWORK OR MASSAGE BEFORE?

IF YES, WHAT TYPE AND HOW LONG AGO?

WHAT IS YOUR PREFERRED LEVEL OF PRESSURE? (CLICK ALL THAT APPLY): ☐ **LIGHT** ☐ **MEDIUM** ☐ **FIRM** ☐ **STRONG**

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS SESSION?

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

IF YES, PLEASE LIST NAMES AND REASON/TREATMENT:

DO YOU HAVE ALLERGIES? PLEASE SPECIFY:

PLEASE REVIEW AND CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CURRENT OR PAST HEALTH:

- ☐ PREGNANCY - HOW MANY WEEKS?
- ☐ BACK INJURIES/PAIN
- ☐ NECK INJURIES/PAIN
- ☐ NUMBNESS, TINGLING OR NERVE PROBLEMS
- ☐ MUSCLE STRAIN/SPRAIN
- ☐ HIGH BLOOD PRESSURE
- ☐ STROKE
- ☐ INSOMNIA
- ☐ HEPATITIS
- ☐ SURGERIES:
- ☐ TMJ SYNDROME
- ☐ DISLOCATIONS/FRACTURES
- ☐ HEADACHES
- ☐ ARTHRITIS
- ☐ HEART CONDITIONS
- ☐ SKIN CONDITIONS: ECZEMA, WARTS, RASHES, FUNGUS…
- ☐ DIGESTIVE DISCOMFORT
- ☐ CANCER - TYPE / YEAR?

☐ AUTO-IMMUNE CONDITION

☐ DIABETES

☐ NAUSEA/FAINTING SPELLS

☐ DEPRESSION

☐ BRUISE EASILY

☐ BLOOD CLOTS

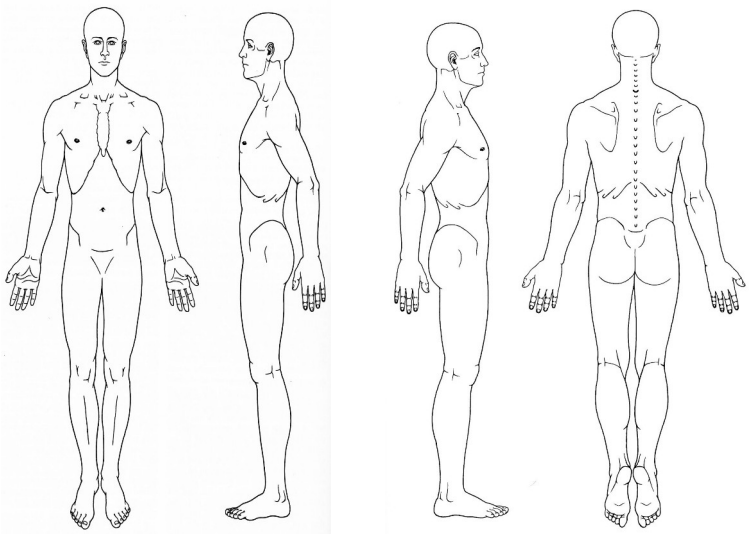
☐ SEIZURES

☐ ANXIETY

☐ OTHER CONDITIONS:

USING THE DIAGRAM TO THE RIGHT:

1. PLEASE INDICATE WITH A **(O)** AREAS YOU WOULD LIKE ADDRESSED.



CONSENT FOR CARE

PLEASE READ THE FOLLOWING INFORMATION, CHECK (✔) YOU UNDERSTAND AND SIGN BELOW:

☐ I acknowledge that the therapeutic bodywork/massage services being provided are not a substitute for medical examination, diagnosis and treatment. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat physical illness.

☐ I understand that bodywork/massage is a therapeutic health aid and is non-sexual in nature. I am aware that any inappropriate behavior will result in an immediate termination of the session and/or future services.

☐ I have read the above information and completed this form to the best of my knowledge. Being that bodywork/massage should not be done under certain medical conditions I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to inform the therapist of any changes in my health and medical condition and that there shall be no liability on the therapist's part should I forget to do so.

☐ By signing this "Release" Form, I hereby release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

SIGNATURE **DATE**

CONSENT TO TREATMENT OF MINOR (if you are 18 years and under):

By my signature below, I hereby authorize to administer bodywork/massage therapy techniques to my child or dependent as they deem necessary.

SIGNATURE OF PARENT OR GUARDIAN **DATE**

- OFFICE USE -

Staff Initial: Location: **LA | PT**