CONSCIOUS CARE MASSAGE THERAPY

CLIENT INTAKE FORM

NAME (LEGAL) _____ D.O.B _____

PREFERRED _____ SEX: ☐ F ☐ M ☐ I

PHONE _____ EMERGENCY CONTACT

EMAIL _____ NAME _____

PRONOUNS _____ PHONE _____

Contact information is for my documentation. You will not be sent marketing material unless you have given explicit permission.

☐ I would like to be sent marketing material

How did you learn about Conscious Care?

Have you received massage therapy or bodywork before? ☐ Y ☐ N

What is your occupation? How do you spend *most* of your time? Job/carer/student?

Please describe the activities and periods of inactivity you engage in with your body. Exercise/classes/hobbies/commitments

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perfom spinal manipulations. I will inform the therapist of my current condition at the time of each visit, and any changes since my previous visit.

Signature:

Please mark any of the following conditions you may have.

- [ ] Acute pain
- [ ] Chronic Pain
- [ ] Neck or spine injury
- [ ] Numbness or tingling
- [ ] Neurological dysfunction
- [ ] Dizziness
- [ ] Headaches/migraines
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Heart attack
- [ ] Stroke
- [ ] Blood clots/DVT
- [ ] Varicose veins
- [ ] Oedema/swelling
- [ ] Rashes, lumps, changes in skin
- [ ] Bruising
- [ ] Open wounds
- [ ] Surgeries
- [ ] Accidents
- [ ] Other...
- [ ] Fatigue (general or chronic)
- [ ] Insomnia/sleep disorders
- [ ] Depression
- [ ] Anxiety
- [ ] Sudden changes in mood
- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Joint replacement
- [ ] Implants
- [ ] Cancer/tumours
- [ ] Lymph node removal
- [ ] Diabetic/complications
- [ ] Infection
- [ ] Urinary tract/kidney infections
- [ ] Liver ailments
- [ ] Fever
- [ ] Cold or flu symtoms
- [ ] Nausea, vomiting or diarrhea
- [ ] Allergies

Are you on any medication?

- [ ] Yes: Please list:
- [ ] No

L R R L