Sample Intake Form

NAME:		DATE:	
STREET:	CITY:	STATE:	ZIP:
HOME TEL:	WORK TEL:	MOBILE TEL:	
OCCUPATION:			
EMAIL:	BIRTH DATE:	REFERRED BY:	

If you do not want to receive an e-newsletter, please check this box. ☐

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your doctor may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? □ **Yes** □ **No** How recently? _____

What are your massage or bodywork goals? _____

What kind of pressure to you prefer? ☐ **light** ☐ **medium** ☐ **firm**

□ **Yes** □ **No** Do you frequently suffer from stress?

□ **Yes** □ **No** Do you have diabetes?

□ **Yes** □ **No** Do you experience frequent headaches?

□ **Yes** □ **No** Are you pregnant?

□ **Yes** □ **No** Do you suffer from arthritis?

□ **Yes** □ **No** Are you wearing contact lenses?

□ **Yes** □ **No** Are you wearing dentures?

□ **Yes** □ **No** Do you have high blood pressure?

□ **Yes** □ **No** Are you taking high blood pressure medication?

□ **Yes** □ **No** Do you suffer from epilepsy or seizures?

□ **Yes** □ **No** Do you suffer from joint swelling?

□ **Yes** □ **No** Do you have varicose veins?

□ **Yes** □ **No** Do you have any contagious diseases?

□ **Yes** □ **No** Do you have osteoporosis?

□ **Yes** □ **No** Do you have any allergies?

□ **Yes** □ **No** Do you bruise easily?

□ **Yes** □ **No** Any broken bones in the past two years?

□ **Yes** □ **No** Any injuries in the past two years?

□ **Yes** □ **No** Do you have tension or soreness in a specific area? Please specify _____

_____

□ **Yes** □ **No** Do you have cardiac or circulatory problems?

□ **Yes** □ **No** Do you suffer from back pain?

□ **Yes** □ **No** Do you have numbness or stabbing pains?

□ **Yes** □ **No** Are you sensitive to touch, pressure or heat in any area?

□ **Yes** □ **No** Have you ever had surgery? Explain below.

□ **Yes** □ **No** Other medical condition, or are you taking any medications I should know about?

Comment _____

_____

This form is strictly confidential.

If you have been diagnosed with cancer, please take time to complete the following questions.

What was your cancer diagnosis? _____ When were you diagnosed? _____

Was there or is there lymph node involvement? □ **Yes** □ **No** Have you had any lymph nodes removed? □ **Yes** □ **No**

If yes, please indicate where and how many nodes: _____

Have you been diagnosed with lymphedema? □ **Yes** □ **No** Want more information about lymphedema □ **Yes** □ **No**

Did you have chemotherapy? □ **Yes** □ **No** When was your last treatment? _____

Did you have radiation? □ **Yes** □ **No** Where? _____Last treatment? _____

Have you had surgery? □ **Yes** □ **No** Explain: _____

Do you have any implanted devices (ex: port)? □ **Yes** □ **No** Where? _____

Is there pain, where? _____

Has the cancer spread? Where? _____

Do you currently or have you experienced any of the following side effects? (Please circle all that apply)

Fatigue	Digestion problems	Acid reflex
Anxiety	Mouth sores	Neuropathy
Memory loss	Heartburn	Others: _____

Do you want more information about managing side effects□ **Yes** □ **No**

For female clients: Are you OK with work around your mastectomy area? □ **Yes** □ **No**

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my therapist if anything changes in my status. I understand that my spa therapist does not diagnose illness or disease, nor prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____