

Initial Client Intake Form

Name _____ Date _____

DOB _____ Contact Number _____

Email* _____ Emergency Contact: _____
(To be added to our informative monthly newsletter)

Address _____ City _____ State ____ Zip _____

Occupation: _____ Hobbies: _____

How did you hear about The Art of Touch? _____

Have you ever received massage therapy before? No Yes Frequency? _____
What type of pressure do you prefer? Light Medium Deep

What are your primary goals for receiving massage? Relaxation Therapeutic Combination

List current medications (include pain relievers and herbal remedies) _____

Have you taken your *most recent* dose of medication? Yes No

List all Medical Conditions, Surgeries or Injuries in the past 4 years, *include dates & treatments received* _____

Please Circle all current or past conditions:

- | | | |
|------------------------|-------------------------|---------------------|
| Headaches | Spinal/Disc problems | Blood clots |
| Fatigue | Lupus | Lymphedema |
| Fever | Sprains | High Blood pressure |
| Sinus | Strains | Low Blood pressure |
| Rashes | Tendonitis | Poor circulation |
| Pain | Bursitis | Varicose veins |
| Athlete's foot/Warts | Stiff or painful joints | Chest pain |
| Infection | Head injuries | Shortness of breath |
| Rheumatoid arthritis | Dizziness | Asthma |
| Osteoarthritis | Loss of memory | Abdominal pain |
| Osteoporosis | Chronic pain | Bowel problems |
| Scoliosis | Depression | Thyroid |
| Broken bones | Stroke | Diabetes |
| Pregnancy weeks: _____ | Heart disease | Fibromyalgia |
| Fibrotic Cysts | Cancer/Tumors | Allergies _____ |

Initial Client Intake Form page 2

Please check if you are experiencing any of the following:

___ Neck/Shoulder/Arm Pain ___ Low back/Hip/Leg Pain ___ Spasms/Cramps where: _____

___ TMJ/Jaw Pain ___ Numbness/Tingling where: _____ ___ Sciatica/Shooting Pain

List areas that you do **not** want massaged: _____

Please read carefully and sign below.

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for Care

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. All body parts may be addressed, except genital and breast areas. Modest draping will be utilized. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my comfort level.

I further understand that massage or bodywork is not a substitute for a 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. It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I 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.

I authorize The Art of Touch to obtain/furnish any and all of my medical records necessary for treatment/payment to and/or from any physician, attorney or insurance provider.

Signature _____ Date _____