Client Intake

Please be aware that all information gathered and topics discussed, as well as any aspect of your treatment will be held in utmost confidence and require written release to be shared at any time.

Client name-_____ Date_____

Occupation _____ **Date of birth** _____

Address _____Zip _____

Phone # _____E-mail_____

How did you hear about us?_____

Are you currently under a physicians care? Yes No
Current medications (drugs, herbs and supplements) _____
_____
_____

Daily life activities- _____
_____
_____

Have you received massage before? _____ When? _____

What are your current goals for massage? _____

What did you like/dislike about previous massage? _____
_____

Please describe your two most pressing concerns/aches/pains/complaints- (check all that apply)

#1 Concern- _____

Severity- mild ___ moderate ___ severe ___
Frequency- constant ___ intermittent ___
Symptoms- increase w/activity ___ decrease w/activity ___
Changes- getting better ___ getting worse ___ no change ___

Treatment received _____

Activities limited by condition _____

#2 Concern- _____

Severity- mild ___ moderate ___ severe ___
Frequency- constant ___ intermittent ___
Symptoms- increase w/activity ___ decrease w/activity ___
Changes- getting better ___ getting worse ___ no change ___

Treatment received _____

Activities limited by condition _____

over>

Health history-

Surgeries- _____
_____

Injuries- _____
_____

Major illnesses_____
_____

Health conditions- (please circle any **current** and/or **previous** conditions)

Muscles and joints-

Arthritis Osteoporosis Scoliosis
Fractures Sprains Strains Bursitis
Disc Problems TMJD Other

Cardiovascular/ Respiratory-

Anemia Angina Arteriosclerosis
Congestive Heart Failure Heart Attack
Heart Disease Hypertension Blood Clots
Irregular Heart Beat Varicose Veins
Phlebitis Asthma Other

Nervous System-

Concussion Epilepsy Stroke
Anxiety Depression Other

Endocrine System-

Diabetes Thyroid Other

Skin conditions-

Abrasions/cuts Rashes Other

Reproductive-

Pregnancy (past or present) Endometriosis
Hysterectomy Other

Comments-
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Comments-
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Comments-
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Comments-
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Consent to treatment-

I affirm that all information I have provided is correct and current to the best of my knowledge. I understand that I will receive therapeutic massage from Aaron Allen LMT. I hereby give my consent to receive massage for the purpose of maintaining good health and establishing and maintaining good physical condition. I recognize that this in no way constitutes diagnosis of any condition nor substitutes the advice of medical professionals. I understand that I may have a witness present for this or any other proceedure, and that my consent to treatment may be withdrawn at any time.

Signature _____ **Date** _____