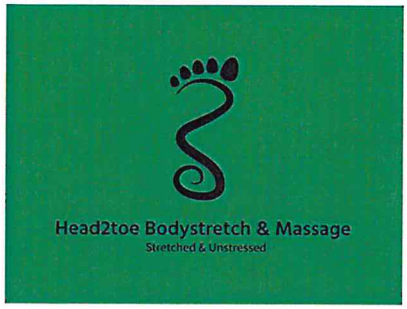
Head2toe BodyStretch & Massage Therapy Client Intake



Patient Information

Name: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary phone: _____ Secondary phone: _____

Email address: _____ Occupation: _____

Emergency contact: _____ Phone: _____ Relationship: _____

How were you referred? _____ Preferred form of communication:_____

Will you be using a Gift Certificate?_____

Have you received Assisted Stretch Or Massage before: Yes _____NO_____

When? _____ Frequency_____ Do you Stretch Regularly? Yes___ how often_____ No_____

Other types of Bodywork Received: (Reiki, Chiropractic, Acupuncture) _____

Health Information

Are you currently under a physician's care for an illness? ____ If so, please explain: _____

Please list any medications that may affect treatment or supplements:

_____

What are your goals for your session Short Term & Long Term

_____

Please list any areas of tension or pain that you would like addressed: _____

Do you have any of the following today: (Y/N)

Sunburn_____ Inflammation_____ Severe Pain _____Headache _____Open cuts, bruises, burns _____

Irritated Skin Rash _____Poison Ivy _____Shingles _____Cold/Flu _____Viral Infection_____

Please mark an (X) by all current conditions and a (P) by all past conditions

__ Abdominal/digestive problems	__ Allergies	__ Anxiety	__ Arthritis/tendonitis
__ Asthma/lung problems	__ Athlete's foot	__ Blood clots	__ Chronic pain
__ Circulatory/heart problems	__Constipation/diarrhea	__ Depression	__ Diabetes
__ Fatigue	__ Headaches	__ Hearing problems	__ Hernia
__ High blood pressure	__ Jaw pain/TMJ pain	__ Low blood pressure	__ Muscle/bone injuries
__ Muscle/joint pain	__ Numbness/tingling	__ Pregnancy	__ Rash/fungus
__ Sinus problems	__ Sleep difficulties	__ Spinal disorders	__ Sprain/strain
__ Tension/stress	__ Vision problems	__ Varicose veins	__ Other _____

Expected Outcome (functional improvement, symptom relief, wellness, relaxation)_____

Elaborate on noted areas above: _____

Please list any RECENT injuries or surgeries: _____

Do you participate in sports, exercise, hobbies, or stress reduction activities? _____ If so what are they?

Please read the following Policies and Sign below:

24 Hour Cancellation Policy- Emergencies arise so for those occasions the first time you will not be charged,. 2nd time a 50% payment applies, 3rd missed appointment will result in full payment for session .

Please arrive 15 min. prior to appointment time to review above Intake form, Use facilities and discuss any questions concerns. Late arrival of more than 15 minutes will require rescheduling and full payment for that session must be made.

I understand that Bodystretch and or Massage is not a replacement for medical care and that no diagnosis will be made.

Signature _____ Date: _____