CONFIDENTIAL CLIENT INTAKE FORM

Amy Moses, LMT
Stone Ridge Massage Therapy

Name:_____Date of Initial Visit_____

Address_____State_____Zip_____

Home Phone_____ Work Phone_____ Email_____

Date of Birth_____Age_____Occupation_____

Referred by_____

In case of Emergency, Contact_____ Phone_____

Have you had massage/bodywork before?_____ What type?_____

What kind of pressure do you like? Light _____ Medium_____ Deep_____

REASON FOR VISIT

What is your primary concern?_____

What are other areas of concern?_____

When did your first notice it?_____What brought it on?_____

Describe any stressors occurring at the time_____

What activities provide relief?_____what makes it worse?_____

Is this condition getting worse?_____interfere with work_____sleep_____ recreation_____

Describe your exercise routine (type, frequency)_____

MEDICAL HISTORY

Are you currently under the care of another health care provider(s)?_____Reason (s)_____

_____

Any recent Surgery or Acute Injury? Please Describe_____

Any type of Breast Surgery? YES NO Prostate Surgery? YES NO

Chemotherapy? YES NO Radiation? YES NO Any Lymph Nodes Removed? YES NO

Current Medications:_____

_____

Allergies: specify allergen and reaction:_____

Supplements/Remedies_____

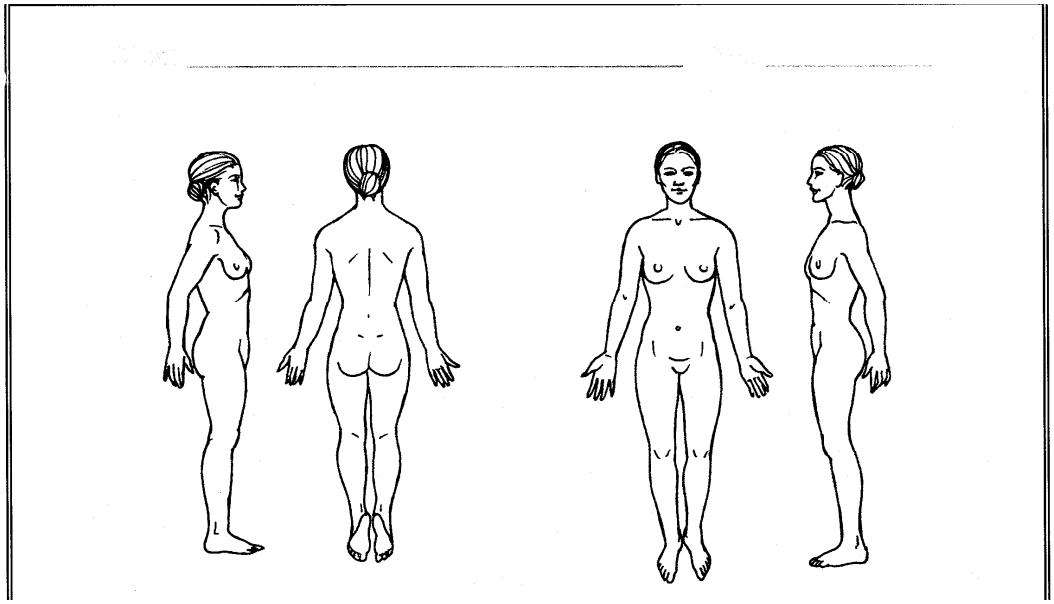
See page 2, ……

Circle any of the following you are *Currently* experiencing
Underline any of the following you have experienced in the *Past*

Headaches (migraine, tension, cluster)			Pins and needles in arms, legs, hands or feet	
Asthma	Cold Hands or Feet	Swollen ankles	Sinus Conditions	Seizures
Skin Disorders: ex: *Acne, Fungus, Psoriasis*			Sciatica	Painful Joints/Swollen Joints
Spinal Problems		Arthritis	Fatigue	Trouble Sleeping
Varicose Veins Blood Clots		Herniated or Bulging discs		High or Low Blood Pressure

Are you, or could you be, pregnant?_____

Mark any areas of current persistent pain or tension on the figures below:



Please read and sign

I understand that payment is due at the time of treatment unless arrangements have been made other wise.

I agree to give at least 24 hours notice of cancellation of appointment. Cases of extreme emergency are considered exceptions to this cancellation policy.

I understand the therapist/practitioner does not diagnose medical illness, disease or any other physical or mental conditions (unless specified under his/her professional scope of practice). As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice). I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.

I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Client signature_____Date_____