

Client Intake Form**Personal Information**

Name _____ Date _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____

Home phone _____ Work Phone _____

Cell Phone _____ Best number to call _____

Profession _____ Activities at Work _____

E-mail Address _____

Yes, sign me up for the monthly F Y`UI !GhUh]cb `A UggU[Y Newsletter with information on new specials or services, coupons, updates, and hours.

Best way to reach you: Phone Email Mail Other _____

Emergency Contact _____ Phone _____

How did you hear about Relax-Station Massage _____

Referred by _____

Physician's Name _____ Clinic Name _____

Clinic Address/Number _____

Massage/Bodywork Experience

1. Have you had a professional massage before? YES or NO (If no, skip to #5)

2. What types of Massage/Bodywork have you had? _____

3. How long have you been receiving massage therapy? _____

4. Frequency of Treatments? _____

5. What are your goals for treatment? _____

6. Are there any areas of your body that you DO NOT want massaged: Circle ANY

Face Scalp Neck Upper Chest Shoulders Stomach Upper Back

Mid Back Lower Back Arms Hands Side of Glutes Legs Feet

Current Health**Please Check One Box per item and Add any Comments****Integumentary System**

| | <i>Yes/Current</i> | <i>Past</i> | <i>No</i> |
|-------------------|--------------------------|--------------------------|--------------------------|
| Boils | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fungal Infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes Simplex | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Warts/Moles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rashes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe Sunburn | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruises easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | | |
| Comments _____ | | | |

Circulatory/Lymph/Endocrine System

| | <i>Yes/Current</i> | <i>Past</i> | <i>No</i> |
|---------------------------|-----------------------|-----------------------|-----------------------|
| Anemia | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Phlebitis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Heart Disease/Condition | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| High Blood Pressure | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Varicose Veins | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Diabetes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Clotting disorders | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Edema | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hodgkin's Disease | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| AIDS/ HIV | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Chronic Fatigue | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lupus | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cold/Flu/Fever(Currently) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hypo/Hyperthyroidism | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Leukemia/Lymphoma | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other _____ | | | |
| Comments _____ | | | |

Respiratory System

| | <i>Yes/Current</i> | <i>Past</i> | <i>No</i> |
|----------------|--------------------------|--------------------------|--------------------------|
| Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | | |
| Comments _____ | | | |

Digestive / Urinary System

| | <i>Yes/Current</i> | <i>Past</i> | <i>No</i> |
|----------------|--------------------------|--------------------------|--------------------------|
| Cirrhosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gallstones | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | | |
| Comments _____ | | | |

Nervous System

| | <i>Yes/Current</i> | <i>Past</i> | <i>No</i> |
|--------------------|-----------------------|-----------------------|-----------------------|
| Multiple Sclerosis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Spinal Cord Injury | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Numbness/tingling | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Headaches | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Stroke | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Seizure Disorder | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Numbness/tingling | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Reduced Sensation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other _____ | | | |
| Comments _____ | | | |

Reproductive System

| | <i>Yes/Current</i> | <i>Past</i> | <i>No</i> |
|-------------------------|--------------------------|--------------------------|--------------------------|
| Breast Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Painful Menstruation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pelvic Inflamm. Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnant | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Prostate Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | | |
| Comments _____ | | | |

Other

| | <i>Yes/Current</i> | <i>Past</i> | <i>No</i> |
|---------------------------------------|-----------------------|-----------------------|-----------------------|
| Hearing impaired | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Visually impaired | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Insomnia | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cancer(other than above) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Alcoholism/Sub. Abuse | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Physical Abuse | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Psychological condition | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Surgery other than stated above _____ | | | |
| Accidents _____ | | | |
| Other Conditions _____ | | | |
| Comments _____ | | | |

Musculo-Skeletal System

| | Yes/Current | Past | No |
|------------------------------|-----------------------|-----------------------|-----------------------|
| Fibromyalgia | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rheumatoid Arthritis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Osteoarthritis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| TMJ dysfunction | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Strains, Sprains, tendonitis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bursitis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Carpal Tunnel Syndrome | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Thoracic Outlet Syndrome | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cramps, Spasms, Sore | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Broken or fractured bones | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Loss of Mobility | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other _____ | | | |
| Comments _____ | | | |

1. List any medications and/or nutritional supplements you are taking _____

2. Do you exercise regularly and/or participate in any sports _____

3. Do you have any allergies or sensitivities _____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course or the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also 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.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____