Spirit Massage & Bodywork®
Release your stress, relax your mind!

HEALTH AND WELLNESS INFORMATION

CLIENT INTAKE FORM 42.3 Rev 6/13

Section 1: Client Information

Name (Last, First MI)				Email Address	Home#	
					Work	
					Mobile	
Age		Height/Weight		Address:	City:	
Sex	M/F	Occupation			State/Zip	

Section 2: Health History

Y	N		DOB	
		Allergies?		
		Are you pregnant? **Due Date:**		
		Have you had any major injuries or surgery in the past 6 months?		
		Do you have any area(s) which are sore or sensitive to the touch?		

DISCLOSURE: *Voluntary: however, failure to provide the information may result in delays or mistreatment in assessing your overall health and well-being.*

PRINCIPAL PURPOSE (S): *An assessment by your massage therapist of your physical condition is needed to determine necessary modalities to be applied and identify any contraindications for massage*

Preference on Massage Pressure (Circle One)

Low	Medium	High
1 2 3	4 5 6	7 8 9

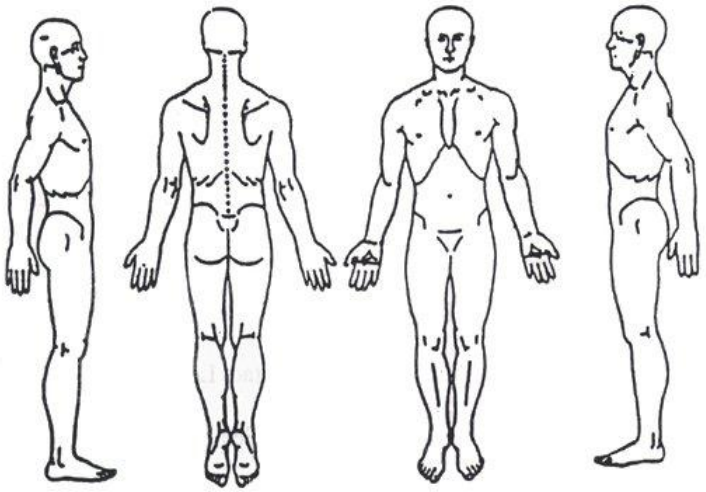
SHADE in the areas where you are experiencing pain, soreness, numbness, or tingling on the figure below. CIRCLE areas of stiffness.

RATE YOUR PAIN on a 0 to 10 scale (Circle One)

0 1 2 3 4 5 6 7 8 9 10

Check conditions or symptoms you currently have or have had in the past:

	Anemia		Heart Disease		Pneumonia
	Appendicitis		Hepatitis		Polio
	Arthritis		Herniated Disc		Rheumatic Fever
	Blood Clots		Herpes		Sinus Problems
	Bronchitis		High Blood Pressure		Stroke
	Cancer		Migraine		Tendonitis
	Diabetes		Muscular Sclerosis		Thyroid Problems
	Epilepsy		Pacemaker		Ulcers
	Fractures		Pinched Nerve		Other



List any medications:

Have you ever received a PROFESSIONAL MASSAGE?	YES/NO	***In case of emergency, contact*** (Name, Relationship, and Phone)?

Please read and sign: I certify that the above information is correct to the best of my knowledge & hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me.

I understand the services offered are not a substitute for medical care and that any information provided by the massage therapist is not diagnostic or prescriptive in nature. I agree to participate and give consent to receive treatment. I have reported all health conditions that I am aware of and will inform my therapist of any changes in my health. I also know that in some cases the therapists may refer me to another health care practitioner as they may feel is necessary for my best interests. I realize that if I do not give pertinent information regarding my health the therapist may not know the best form of treatment to take and that in some cases my well-being may be at risk

I acknowledge that my therapist has given me an appointment time which will be exclusively reserved for me. Failure to provide 24 hours notice of cancelation may result in my account being charged for full session.

Signature _____ Date: _____

Referred by _____

{Please print name]