BodyWorx Therapy

New Client Intake Form

Date of Initial Visit: _____

Personal Information:

Name: _____ Email: _____

Phone (Cell): _____ Phone (Home): _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Occupation: _____

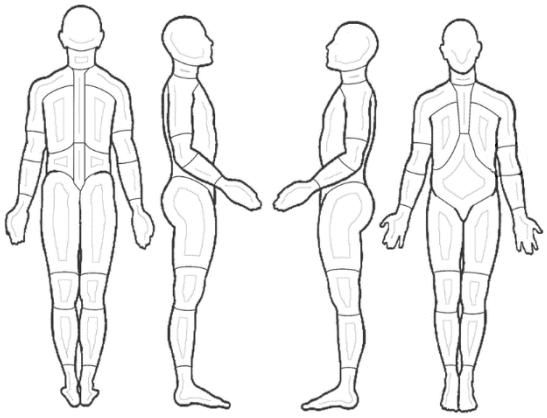
Emergency Contact: _____ Phone: _____

How did you hear about Bodyworx Therapy? _____

The following information will be used to help plan safe and effective bodywork sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? ☐ Yes ☐ No
   If yes, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? ☐ Yes ☐ No
   If yes, please explain: _____
3. Do you have any allergies to oils, lotions, or ointments? ☐ Yes ☐ No
   If yes, please explain: _____
4. Do you have sensitive skin? ☐ Yes ☐ No
5. Check if you are wearing any of the following: ☐ contact lenses ☐ hearing aid ☐ dentures
6. Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No
   If yes, please describe _____
7. Do you perform any repetitive movement in your work, sports, or hobby? ☐ Yes ☐ No
   If yes, please describe _____
8. Do you experience stress in your work, family, or other aspect of your life? ☐ Yes ☐ No
   If yes, how do you think it has affected your health? ☐ muscle tension ☐ anxiety ☐ insomnia ☐ irritability
   ☐ other _____
9. Do you have any goals in mind for this massage session? ☐ Yes ☐ No
   If yes, please explain _____
10. Is there an area of the body where you are experiencing tension, stiffness, pain or other discomfort? ☐ Yes ☐ No
    If yes, please identify _____

Circle any specific areas you would like focused on during the session:



Medical History:

11. Are you currently under medical supervision? ☐ Yes ☐ No

    If yes, please explain: _____

12. Do you see a chiropractor? ☐ Yes ☐ No

    If yes, how often? _____

13. Are you currently taking any medication? ☐ Yes ☐ No

    If yes, please list: _____

14. Please check any condition listed below that applies to you:

☐ contagious skin condition	☐ osteoporosis
☐ open sores or wounds	☐ deep vein thrombosis/blood clots
☐ easy bruising	☐ joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
☐ recent accident of injury	☐ cancer
☐ recent surgery	☐ epilepsy
☐ artificial joint	☐ headaches/migraines
☐ sprains/strains	☐ tennis elbow
☐ current fever	☐ diabetes
☐ swollen glands	☐ decreased sensation
☐ allergies/sensitivity	☐ back/neck problems
☐ heart condition	☐ Fibromyalgia
☐ high or low blood pressure	☐ TMJ
☐ circulatory disorder	☐ carpal tunnel syndrome
☐ varicose veins	☐ pregnancy if yes, how many months?
☐ atherosclerosis	

Please explain any condition that you have marked above: _____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered.
Informed written consent must be provided by parent or legal guardian for any client under the age 17.

I,_____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or another qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists 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 of the session given should be construed as such. Because massage 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapy reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client: _____ Date: _____

Signature of therapist: _____ Date: _____