

CLIENT INTAKE FORM

I _____ understand that Be Well has a 24-hour cancellation/reschedule policy applies to all appointments. I understand that my therapist respects my appointment time and reserves it for me exclusively. If 24-hour notice is not given I understand that I will be billed for the intended appointment.

Sign: _____ Date: _____

Name _____ Date _____ Date of Birth _____

Phone-Home _____ Work _____ Cell/Pager _____

Address _____ City _____ State _____ Zip _____

E-mail address: _____

How did you hear about us/Who referred you? _____

Occupation _____ Employer _____

Work Responsibilities _____

Emergency Contact _____ Relationship _____

Phone-Work _____ Home _____ Cell/Pager _____

CURRENT HEALTH

Have you ever received massage therapy before?(Please circle) Yes No Frequency: _____

Reason for today's visit: _____

Desired results of today's session: _____

Today's primary concern or goal: _____ Other: _____

Classify concern: ___ Minor ___ Problematic ___ Major

Classify type: ___ Recurring ___ Getting worse ___ Getting better

Have you had this concern/goal before? Yes No Explain: _____

Have you received treatment for this before? Yes No Explain: _____

List activities affected: _____

Current medications (including over-the-counter pain relievers and herbal remedies) _____

Stress reduction/exercise activities: _____ Frequency: _____

Is there anything I should know to ensure your comfort regarding: _____

Allergies/sensitivities: ___ oils, ___ lotions, ___ scents, ___ detergents, ___ foods, ___ animals, other: _____

Contact lenses (the face pillow may put pressure on your eyes): _____

Hearing abilities (communication is helpful during the session): _____

Hair, make-up, clothes (will you return to work after your session?): _____

Movement abilities (i.e. getting on and off the table, pillows, etc.): _____

Comments:

PREVIOUS HISTORY: (list in chronological order, give dates or ages, and treatment received)

Surgeries: _____

Accidents: _____

Broken bones: _____

Had whiplash: _____

Major illnesses: _____

CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU

Skin

Boils
Fungal infections
Herpes simples
Warts
Eczema
Psoriasis
Skin cancer

Circulatory

Anemia
Thrombophlebitis
Deep vein thrombosis
High blood pressure
Heart disease
Varicose veins
Clotting disorders
Chest pains

Digestive

GERD (reflux)
Ulcers
Crohn's disease
Ulcerative Colitis
Irritable bowel Syndrome
Gallstones/Gall trouble
Cirrhosis
Hepatitis

Reproductive

Breast cancer
Endometriosis
Ovarian Cysts
Prostate Cancer
Painful menstruation
Are you pregnant?

Musculoskeletal

Fibromyalgia
Rheumatoid arthritis
Osteoarthritis
TMJ dysfunction
Strains, sprains or tendonitis
Carpal tunnel syndrome
Thoracic outlet syndrome
Slipped disc /rupture/hernia ion

Nervous

Depression
Multiple sclerosis
Post polio syndrome
Headaches
Stroke
Seizure disorders
Reduced sensation
Sleep disorders
Chemical dependency

Lymph/Immune

Edema
Leukemia/lymphoma
HIV/AIDS
Chronic fatigue syndrome
Lupus
Other auto-immune disorders
Removed lymph nodes
Dissected lymph nodes
Lipedema

Respiratory

Asthema
Emphysema
Sinusitis
Tuberculosis
Allergies

Endocrine

Diabetes
Hypothyroidism
Hyperthyroidism

Urinary

Kidney stones
Renal failure
Incontinence

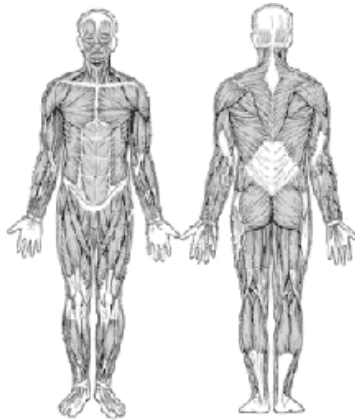
Other: _____

Comments: _____

MARK ON FIGURES ALL AREAS OF:

Pain, tenderness with **O's**
Swelling, stiffness with **X's**

Numbness, tingling with **Z's**
Scars, bruises, open wounds with **H's**



RATE SEVERITY OF ALL SYMPTOM AREAS FROM 1-10:

(1=I feel like a newborn baby, 10=Put me out of my misery)

1 2 3 4 5 6 7 8 9 10

If you are in pain describe what you do that causes pain, and what activities tend to make it worse:

Do you have any questions about massage? _____

CONSENT FOR CARE

(If you have a specific medical condition or specific symptoms, massage / bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.) I understand that 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 this session, I immediately inform the therapist so that the pressure and / or strokes may be adjusted to my level of comfort. I further understand that massage / bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage / bodywork 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 / 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I neglect to do so. It is also understood 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.

Signature _____ Date _____