Client Intake Form

Date: _____

Name_____ Sex: Female () Male ()

Address:_____

City:_____ Province:_____ Postal:_____

Phone#:_____ Email: _____

Date Of Birth:_____ Occupation:_____

Doctor Name & #:_____

Emergency Contact Name & #:_____

Reason For Treatment/ Primary Complaint:_____

_____

Trouble Sleeping (Y) (N) And Why:_____

Any Other Therapies, What And Why:_____

_____

Any Sports Or Activities:_____

_____

Any Accidents Or Operations:_____

_____

Any Medication And Why:_____

_____

Any other Information: _____

_____

All the above information is accurate and true to the best of my ability.

Client Initials:

Please Circle all that apply:

Musculo-Skeletal Headaches - Joint stiffness/swelling - Spasms/cramps - Broken/fractured bones - Strains/sprains – Back or hip pain - Shoulder, neck, arm, hand pain - Leg, foot pain - Chest, ribs, abdominal pain - Jaw pain/TMJ - Tendinitis – Bursitis - Arthritis - Osteoporosis - Scoliosis - Bone or joint disease

Other: _____

Circulatory and Respiratory: Dizziness - Shortness of breath – Fainting - Cold feet or hands - Cold Sweats - Swollen ankles - Pressure sores - Varicose veins - Blood clots - Stroke - Heart condition - Allergies - Sinus problems - Asthma - High blood pressure Low blood pressure

Other: _____

Skin: Rashes - Allergies - Athlete's Foot - Warts - Moles - Acne - Cosmetic surgery
Other: _____

Reproductive System Pregnancy () Current ()Previous - PMS - Menopause - Pelvic Inflammatory Disease - Endometriosis - Hysterectomy - Prostate problems

Other:_____

Digestive: Nervous stomach – Indigestion – Constipation - Intestinal gas/bloating - Diarrhea – Diverticulitis - Irritable bowel syndrome - Crohn's Disease - Colitis
Other:_____

Nervous System: Numbness/tingling -Twitching of face – Fatigue - Chronic pain - Herpes – Shingles – Epilepsy - Multiple Sclerosis - Muscular Dystrophy - Spinal cord injury

Other: _____

I (The Client) understand that the Massage Therapist is providing massage therapy services within their scope of practise. I hereby consent for my therapist to treat me with massage therapy for above noted purpose including assessments, examinations and techniques recommended by my therapist. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical and mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and this risks have been explained to me and I assume this risks. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form provided by my therapist and disclosed to the therapist all the medical conditions affecting me.

It is my responsibility to keep the massage therapist updated on my medical history. The information provided is true and complete to the best of my knowledge. I have read the above noted consent and I have had by signing this form, I confirm my consent to treatment. I understand that at any time I experience pain or discomfort I will communicate to the therapist so treatment may be adjusted, also I may withdraw my consent at any time and treatment will be stopped.

_____ _____

Client Name Date

_____ _____

Client **Or** Guardian Signature Therapist Signature

Cupping Consent:

Massage Cupping technique is to promote health and healing by: loosening soft tissue and connective tissue, scarring and adhesions moving stagnation and increasing lymphatic flow and circulation. These cups are moved over the skin using gliding, shaking, popping and rotating techniques while gently pulling up on the cup, or may be parked for a short time to facilitate joint mobilization or soft tissue release. Suction reaches deep into the soft tissue, attachments and organs. Another benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them. Potential reactions to Cupping are temporary and may include discoloration due to toxins and old blood being brought to the surface, Post tenderness, Redness and Itching due to increased vaso-dilation and/or inflammation brought to the surface, Decreased Blood Pressure

People who are on blood thinners should not experience Cupping. If you start taking such medication please inform the therapist so your treatment plan can be adjusted.

I consent to Massage Cupping _____

Signature and Date