a fine balance
therapeutic massage & bodywork

Client Intake Form

Name: ____Date: ________
Address: ____
City: ___________________________________ State: _________ Zip: _____________
Best Phone #: ______________________________ Alternate Phone #: ________________
Email: __________________________________ May I contact you via email?__________
Date of Birth: ______________________________ Occupation: _______________________
In Case of Emergency, Please Notify:
Name: ____ Telephone #: _________________
Relationship: ____
Referred By: ____
Present symptoms: What is your major complaint or condition you want to improve? _____________
____
What are your intentions or expectations for this visit? _________________________________
____
Are you now under medical/therapeutic treatment? o Yes o No If yes, for what condition? _______
List any medications (including aspirin) and nutritional supplements you are taking: ______________
____
Describe the exercise activities you do (include frequency): _______________________________
____
List other therapies you receive: ____
____
Please list (date and description) any accidents or operations: ____________________________
____
Please list any additional comments regarding your health and well-being: ____________________
____

Cancellation Policy: 24-hour notice is required for cancellations. If you must cancel on short-notice and want to avoid paying a cancellation fee in the amount of the massage, send a friend or relative in your place.

By signing on the reverse, you acknowledge and agree to AFB;s cancellation policy.

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal
o Headaches
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Back, hip pain
o Shoulder, neck, arm, hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease
o Other: ____________________

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Swollen ankles
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Allergies/Asthma
o High/low blood pressure
o Lymphedema
o Other: ____________________

Skin
o Rashes
o Allergies
o Athlete's Foot
o Warts
o Moles
o Acne
o Cosmetic surgery
o Other: ____________________

Digestive
o Nervous stomach
o Indigestion
o Constipation/ Diarrhea
o Intestinal gas/bloating
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Adaptive aids
o Other: ____________________

Nervous System
o Numbness/tingling
o Fatigue
o Chronic pain
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury
o Other: ____________________

Reproductive System
o Current Pregnancy:
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Depression/Anxiety
o Drug use __________________
o Alcohol use _______________
o Nicotine use _______________
o Caffeine use _______________
o Hearing impaired
o Visually impaired
o Bladder infection
o Diabetes
o Fibromyalgia
o Cancer
o Infectious disease (please list)
____
o Other congenital or acquired disabilities (please list) _______
o Surgeries _________________
o Other: ____________________

For clients who need mobility assistance, please give your
height: ________ weight: ________

Please list any additional comments regarding your health and well-being: ________________________

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: ________________________________ Date: ______________