Balanced Soul Massage
Client Intake Form

Client Contact Information

Name:____Occupation: ______________________________________

Address:____City:____

State:_____________ Zip:_____________ Phone:________________________________ Cell: ______________________________

E-mail:____

Date of Birth:________________________________ Gender: M F Referred By:____

Emergency Contact:____ Phone:____

Massage Information

1. Have you ever received professional massage/bodywork before? Yes No
2. How recently/how often? _________________________________
3. What kind of pressure do you prefer? Light Medium Firm
4. **AVOID** these areas:

Face Head Neck Arms Shoulders Abdominals Back Glutes Legs Feet

5. Is this massage/bodywork medically necessary (Is it for a medical condition, injury, surgery)? Yes No

If yes, do you have a physician's referral/prescription? Yes No

6. List your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

____

____

7. Do these symptoms interfere with your activities of daily living (sleep, exercise, work, etc.)? Yes No

Explain:

____

____

8. List the medications you currently take (prescribed and over the counter):

____

____

9. Are you pregnant? Yes No If yes, due date? ___________________
10. Are you wearing a hairpiece? Yes No
11. Are you wearing contacts? Yes No
12. Are you wearing dentures? Yes No

Health History

1. Please list any surgeries or injuries in the past that may influence massage:

____

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2. Circle any of the following health conditions that you currently have:

Blood clots Infections Congestive heart failure Contagious disease Pitted edema

Please answer honestly, as massage may not be indicated for the above conditions.

3. Please indicate conditions that you have or had in the past. Explain, in detail, including treatment received.

Current Past Muscle or joint pain ______________________________

Current Past Muscle or joint stiffness ______________________________

Current Past Numbness or tingling ______________________________

Current Past Swelling ______________________________

Current Past Bruise easily ______________________________

Current Past Sensitive to touch/pressure ______________________________

Current Past High/low blood pressure ______________________________

Current Past Stroke, heart attack ______________________________

Current Past Varicose veins ______________________________

Current Past Shortness of breath ______________________________

Current Past Cancer ______________________________

Current Past Neurological (e.g. MS, Parkinson's) ______________________________

Current Past Epilepsy, seizures ______________________________

Current Past Headaches, migraines ______________________________

Current Past Dizziness, ringing in the ears ______________________________

Current Past Digestive conditions (e.g. Crohn's, IBS) ______________________________

Current Past Gas, bloating, constipation ______________________________

Current Past Kidney disease, infection ______________________________

Current Past Arthritis (rheumatoid, osteoarthritis, gout) ______________________________

Current Past Osteoporosis, degenerative spine/disk ______________________________

Current Past Scoliosis ______________________________

Current Past Broken bones ______________________________

Current Past Allergies ______________________________

Current Past Diabetes ______________________________

Current Past Endocrine/thyroid conditions ______________________________

Current Past Depression/anxiety ______________________________

Current Past Memory loss, confusion, easily overwhelmed ______________________________

Current Past Chronic Pain ______________________________

Comments:

____

____

Consent for Treatment

If I experience any discomfort or pain during this session, I will immediately inform the practitioner 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 see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners 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 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand 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. Understanding all of this, I give my consent to receive care.

Client Signature: ______________________________ Date: ______________

Parent or Guardian Signature (in case of a minor): ______________________________ Date: ______________