Holistic Touch

MASSAGE AND BODYWORK INTAKE FORM

Name:____ Date:____________________________

Address:____ Date of Birth :____________________

Phone:___________________________home
___________________________cell
Occasionally we might text appointment reminders or special offers.
Please initial if you do not want to receive these messages____

Email:____________________________
Occasionally we might email you regarding special promotions or events. Please initial if you do not want to be emailed ______

Emergency Contact :__________________________ Phone:____________________ Relationship:________________

Whom can we thank for referring you? _____________________________________

MASSAGE/BODYWORK INFORMATION

Is this your first massage or energy work session? ____________ When was your last session? __________________

What type of pressure do you prefer (light, firm, moderate, deep)? ____

Are there any areas of sensitivity? ____

Do you have problems laying face down?(if yes describe)____

Are you claustrophobic? ___________ (if yes, what helps) ____

Is there anything else that your therapist should know about? ____

What are your goals for this session?____

HEALTHCARE PROVIDERS

Primary Health Care Provider:__________________________
Address: ________________________________
Phone:__________________________________

Other Providers:____________________________
Address:___________________________________
Phone:____________________________________

I give permission for Holistic Touch or its providers to consult with health care providers if needed and/or release any information as requested to my health care provider(s) or insurance companies. If yes, please initial ________ Permission may be revoked at any time by providing Holistic Touch with written notice.

I understand that body and energy work practitioners do not diagnose disease or provide medical treatment. I understand that massage therapy and/or energy work is for the purpose of stress relief, release from muscular tension, improve circulation, among other health benefits. I understand that body work is for therapeutic health and non-sexual. I understand that the therapist may terminate the session if her/she feels discomfort and I will be held responsible for the full cost of the session. I have answered all medical questions on the reverse side truthfully and to the best of my ability. I do understand that there are certain contraindications that may require a release from my doctor even if I have received body work in the past. I understand that massage therapy/energy work is not intended to replace appropriate medical care and I will consult with my doctor as appropriate. I forever release Holistic Touch, the practitioners, and their insurers from all liability of any nature whatsoever now and in the future for injury or damage which may occur to myself as a result from receiving massage therapy. I further agree to hold harmless and defend the practitioner of and from all actions, claims, or other legal or administrative action. I agree to notify Holistic Touch of any changes to my medical information.

I understand that Holistic Touch requires a 24 hour cancellation policy. We understand that emergencies occur and any same-day cancellation charges that might occur will be on a case-by-case status. Any no-call/no-show appointments will be charged the full service fee which may result in any discount that I have received to be forfeited.

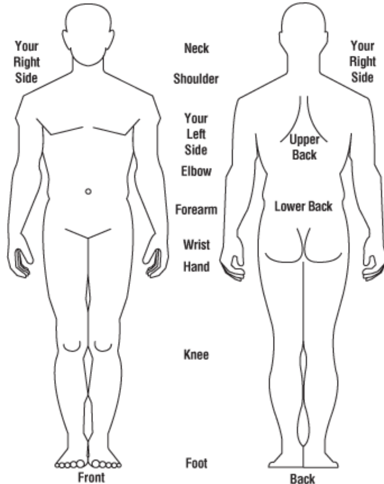
Signature:____ Date:_________________________________

Print Name:_______________________________________ Therapist/Service Provider:________________

HEALTH HISTORY

Please list typical daily activities (repetitive movement, work, sitting at a desk, continuous standing, exercise, etc):
____
____

Do you have any areas of concern? Please indicate on the figures below:



Key:
0 – pain
X – avoid
- bruising/open wounds
* - stiffness
^ - tender

For Therapist Use:
____
____
____
____
____
____
____
____

What makes your condition better? What makes it worse? ____

Does your condition interfere with work, home life, sleep, or recreation? Please explain ___________________________
____

What treatment are you receiving or have you received for this condition? __________________________________

Please check current or previous conditions:

MUSCULO-SKELETAL

Yes	No	
( )	( )	Bone or Joint Disease
( )	( )	Tendonitis/Bursitis/Arthritis
( )	( )	Scoliosis
( )	( )	Jaw Pain (TMJ)
( )	( )	Muscle Cramps
( )	( )	Sprain or Strain
( )	( )	Swelling

PRESENT CONDITIONS:

Yes	No	
( )	( )	Cuts, Burns, Bruises
( )	( )	Rashes
( )	( )	Athlete's Foot
( )	( )	Cold, Flu, Fever

RESPIRATORY:

Yes	No	
( )	( )	Asthma/Breathing Difficulty
( )	( )	Emphysema
( )	( )	Sinus Problems

DISEASES:

Yes	No	
( )	( )	Diabetes
( )	( )	Cancer Type ________________
( )	( )	HIV/AIDS
( )	( )	Hepatitis Type ______

CIRCULATORY:

Yes	No	
( )	( )	Heart Disease/Condition
( )	( )	Varicose Veins/Blood Clots
( )	( )	High Blood Pressure Controlled? ____
( )	( )	Low Blood Pressure Controlled?____
( )	( )	Lymphedema

NERVOUS SYSTEM

Yes	No	
( )	( )	Herpes/Shingles
( )	( )	Dizziness/Ringing In Ears
( )	( )	Pinched Nerve
( )	( )	Numbness/Tingling

OTHER:

Yes	No	
( )	( )	Chronic Fatigue
( )	( )	Chronic Pain
( )	( )	Sleep Disorder
( )	( )	Migraines/Headache
( )	( )	Anxiety/Stress
( )	( )	Depression
( )	( )	Wear Contact Lenses
( )	( )	Wear Dentures

ALLERGIES:

Yes	No	
( )	( )	Hay Fever/Seasonal
( )	( )	Medications
( )	( )	Lotions/Oils Type _______________
( )	( )	Essential Oils Scent _____________
( )	( )	Fragrance
( )	( )	Nuts

WOMEN:

Yes	No	
( )	( )	Currently Pregnant Due Date:______
( )	( )	Postpartum Date Delivered:_______
( )	( )	PMS

List All Medications Including Pain Relievers:____

List Any Injuries or Illness within the last 10 years, including date and treatment: _________________________
____