SERENITY MASSAGE AND BODYWORKS CLIENT INTAKE FORM

PAIN RELIEF & MEDICAL MASSAGE

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

EMAIL: _____ PHONE: _____

CONTACT PREFERENCE: Email: ____ Phone: _____ Text: _____

REASON FOR TREATMENT AND SPECIFIC GOALS FOR THIS SESSION: _____

_____

_____

AREAS OF STRESS, PAIN OR TENSION: _____

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? YES___ NO___

IF YES, DO YOU HAVE ANY LIKES OR DISLIKES? _____

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? YES___ NO___
IF YES, HOW FAR ALONG? _____

PLEASE CHECK IF YOU HAVE / HAD ANY OF THE FOLLOWING CONDITIONS:

___ Heart Conditions	___ High Blood Pressure	___ Vascular/Blood Disorders
___ Skin Disorders	___ Immune Disorders	___ Stomach Disorders
___ Diabetes	___ Cancer	___ Respiratory Disorders
___ Broken Bones	___ Edema	___ Neuropathies
___ Breast/Augmentation		___ Allergies to Oils / Creams or Scents

PLEASE EXPLAIN EACH CONDITION MARKED: _____

_____

_____

___ MEDICAL CONDITIONS NOT LISTED ABOVE THAT YOUR THERAPIST SHOULD KNOW ABOUT?

PLEASE EXPLAIN_____

___ DRUGS OR MEDICATIONS?

PLEASE LIST_____

___ RADIATION / CHEMOTHERAPY TREATMENT? HOW LONG? _____ LAST TREATMENT? _____

___ HERNIATED / BULGING / DEGENERATIVE DISCS? WHERE? _____

PLEASE ADVISE US OF ANY HEALTHCARE PROFESSIONAL YOU ARE SEEING FOR ANY MEDICAL CONDITION:

_____

___ EXERCISE / STRETCHING HABITS? TYPE & HOW OFTEN? _____

_____

PAIN ASSESSMENT

PLEASE CHECK THE FOLLOWING SYMPTOMS THAT YOU HAVE:

___ HEADACHES ___ NECK PAIN ___ UPPER BACK PAIN ___ LOWER BACK PAIN

___ SHOULDER PAIN ___ ARM PAIN ___ HAND PAIN ___ HIP PAIN

___ BUTTOCKS PAIN ___ LEG PAIN ___ FOOT PAIN ___ OTHER_____

_____

PLEASE CHECK THE FOLLOWING THAT DESCRIBES THE PAIN YOU HAVE:

___ SHARP ___ SHOOTING ___ DULL ___ ACHING

___ BURNING ___ ELECTRIC ___ OTHER _____

ARE YOU MISSING WORK DUE TO PAIN? ___ YES ___ NO, IF YES, HOW OFTER? _____

_____

DO YOU KNOW THE CAUSE OF THE PAIN? ___ YES ___ NO, IF YES, PLEASE DESCRIBE:

_____

_____

WHEN DID YOUR PAIN SYMPTOMS BEGIN? _____

WHAT REDUCES OR ELIMINATES THE PAIN?

___ LYING DOWN ___ SITTING ___ WALKING ___ BENDING ___ OTHER_____

WHAT MAKES YOUR PAIN WORSE?

___ LYING DOWN ___ SITTING ___ WALKING ___ BENDING ___ OTHER_____

PAST TREATMENTS:

HAVE YOU HAD SURGERY? ___ YES ___ NO, IF SO WHEN? _____

WHAT DIAGNOSTIC TESTS HAVE YOU HAD? ___ CT SCAN ___ MRI ___ X-RAY ___ EMG / NCS

RESULTS FROM DIAGNOSTICS? _____
Please provide copy of the "Impression" section (written in laymen terms) if available.

DO / DID YOU HAVE THE FOLLOWING TREATMENTS FOR YOUR PAIN?

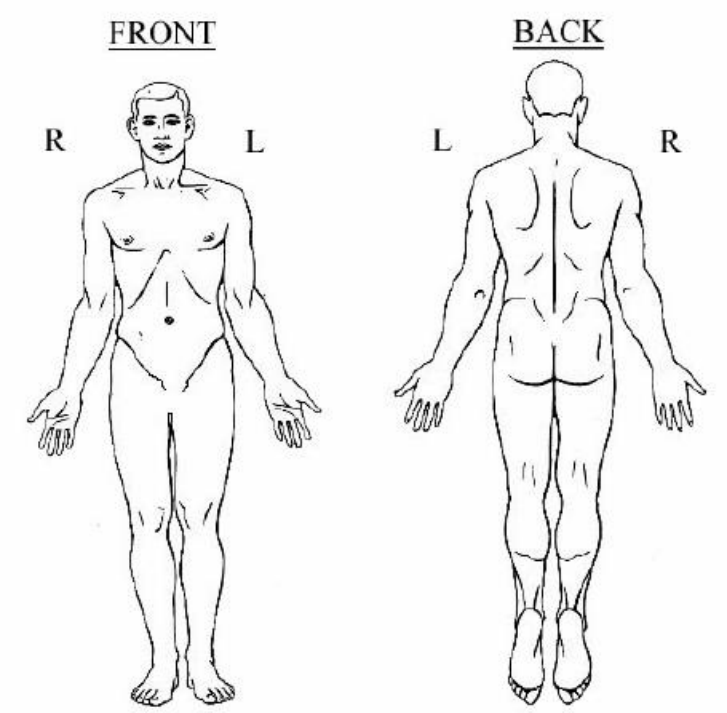
___ INJECTIONS. WHEN WAS THE MOST RECENT? _____ DID THEY HELP? _____

___ PHYSICAL THERAPY. WHAT DOES IT CONSIST OF? _____

PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10, WITH 1 BEING NO PAIN AND 10 BEING THE MOST SEVERE:

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10

PLEASE USE AN X TO MARK THE AREAS OF YOUR BODY THAT HURT:



DRAPING (COVERAGE) WILL BE USED DURING THE SESSION AND ONLY THE AREAS BEING MASSAGED WILL BE UNDRAPED. TREATMENT WILL INCLUDE MASSAGE OF THE FOLLOWING AREAS OF YOUR BODY EXCEPT ANY CONTRAINDICATIONS THERAPIST DETERMINES DURING INTAKE AND ASSESSMENT: HEAD, FACE, NECK, SHOULDERS, BACK, CHEST, ARMS, HANDS, ABDOMEN, BUTTOCKS, LEGS AND FEET.

FEMALE BREAST TISSUE WILL NOT BE MASSAGED UNLESS MEDICALLY NECESSARY.

TREATMENT WILL INCLUDE DEEP AND SOFT TISSUE MASSAGE, NEUROMUSCULAR THERAPY, TRIGGER POINT, MYOFACIAL RELEASE, AND THERAPEUTIC STRETCHING.

IF AT ANY TIME I FEEL UNCOMFORTABLE FOR ANY REASON, I WILL ASK MY THERAPIST TO END THE SESSION.

I UNDERSTAND THAT THE MASSAGE I RECEIVE IS FOR THE PURPOSES OF BUT NOT LIMITED TO: FULFILLING A PRESCRIPTION OF A PHYSICIAN, STRESS REDUCTION, RELIEF FROM MUSCULAR TENSION, SPASM OR FOR INCREASING CIRCULATION AND ENERGY FLOW, RELAXTION, AND GENERAL WELL BEING. I UNDERSTAND THAT MASSAGE PRACTITIONERS DO NOT DIAGNOSE ILLNESS, DISEASE, OR ANY PHYSICAL OR MENTAL DISORDERS, NOR DO THEY PRESCRIBE MEDICAL TREATMENT, PHARMACEUTICALS, OR PERFORM SPINAL THRUST MANIPULATIONS. MASSAGE THERAPY IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATIONS OR DIAGNOSIS. BECAUSE A MASSAGE THERAPIST MUST BE AWARE OF EXISTING PHYSICAL CONDITIONS, I HAVE STATED ALL MY KNOWN MEDICAL CONDITIONS AND TAKE IT UPON MYSELF TO KEEP THE MASSAGE THERAPIST UPDATED ON MY CONDITIONS ON ALL FUTURE SESSIONS.

I HOLD HARMLESS AND AGREE TO INDEMNIFY SERENITY MASSAGE AND BODYWORKS AND ITS THERAPISTS FOR ANY CLAIMS, DAMAGES, LOSSES, EXPENSES, COSTS AND LIABILITIES ARISING FROM THE DELIVERY AND RECEIPT OF SERVICES.

SIGNATURE: _____ DATE: _____

SIGNATURE OF MASSAGE THERAPIST _____ DATE: _____