NEW CLIENT INTAKE FORM

# Julie A Crispin LMT

NAME: _____BIRTHDAY ____/____/_____ AGE: _____

ADDRESS:_____WORK #: _____

CITY/STATE/ZIP: _____EMAIL: _____

PHONE: _____REFERRED BY: _____

EMERGENCY CONTACT: _____PHONE #: _____

**Medical Questions:**

Occupation: _____ Employer: _____

Physician: _____ Last Visit: _____ Phone #:_____
May I contact if needed? Yes / No

Please list all substances you are currently taking this week including prescriptive medicines, supplements, herbs or homeopathic remedies:

How are you feeling today?

How recently have you received a professional massage? What for? Results? What you liked or disliked?

What are your goals for this session and how may I assist you in meeting those goals?

Have you consumed alcohol or other recreational drugs prior to this treatment today? Yes No
**This may effect what type of body work I can safely perform – there is no judgment. Please answer honestly.*

Do you have any allergies? (If so, what) _____
Please list any surgeries you have had and the dates:
_____

Would you like aromatherapy included in your session? Yes No
*are there any scents to which you have an aversion?_____
*are there any scents that you greatly enjoy? _____

PLEASE CIRCLE ALL THAT APPLY TO ANY HEALTH ISSUES YOU MAY HAVE ENCOUNTERED:
*use the space on the back to provide dates and details of conditions, injuries, illness or accidents.

| COMMON CONDITIONS | SYMPTOMS | SYSTEMS |
|---|---|---|
| Arthritis | Abnormal Energy | Cardiovascular (heart & blood vessels) |
| Diabetes | Dietary Issues | Endocrine (glands) |
| High / Low Blood Pressure | Fever | Gastrointestinal (ulcers, IBS, constipation…) |
| Cancer | Inflammation | Musculoskeletal (MS/MD) |
| Varicose Veins | Menstrual | Immune |
| Epilepsy / Seizures | Numbness | Neurological |
| Repetitive Strain Injury | Pregnancy (due date?) | Psychological |
| TMJ Syndrome | Urinary | Headaches |
| Sleep Problems | Integumentary (skin) | |
| Back Pain | Frequent Stress | |

OTHER:_____
_____

CIRCLE AS MANY AS APPLY: I am interested in receiving or learning about:

TRIGGER POINT HOT STONE CRANIAL SACRAL POLARITY THERAPY SWEDISH

Is there anything I should know about you that hasn't been asked on this form? You may simply say yes and we can talk about it?

What do you do for exercise / physical activity: _____ How often? _____

What do you do when you are stressed? _____Fun / Relaxation: _____

Please rate you stress level on average:
1----------10
low high

**IF YOU ARE WEARING CONTACTS OR DENTURES, YOU MAY WISH TO REMOVE THEM.**

*Client Informational Statement:
By my signature, I state that I will receive a therapeutic massage for the purpose of maintaining good health and physical condition. I also understand th the therapist is NOT legally permitted to diagnose or treat injuries or diseases and that the massage should not take the place of a doctor's care when indicated. I understand that it is recommended that I concurrently work with a Primary Care Provider for any condition I may have. I have stated all my known medical conditions, medications, and/or injuries I have or have had in the past. I have answered all questions honestly, and will inform the therapist of any changes in my status. The therapist shall bear no responsibility should I neglect to do so. I understand some of the risks that are involve with massage therapy, including but not limited to: bruising, transient changes in blood pressure, pain (soreness) in the muscles, joints and rash. I do not expect the provider to be able to anticipate and explain ALL risks and complications.

I wish to rely on the provider to exercise good judgment during the course of the procedure, which the provider feels at the time, based upon the facts the known, is in my best interest. I also understand that the therapist may request a change in treatment or behavior should either be experiencing discomfo inappropriate for the situation. Such discomfort may include, but is not limited to, physical pain, sexually suggestive behavior or inappropriate personal remarks or requests. The therapist reserves the right to refuse service to anyone for any reason. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.
Client information will not be released to anyone other than the client or with client's written permission.

**NOTE: Please give 24 hours notice if you need to reschedule your appointment. "No show's" and late cancellations will be billed at $25.**

CLIENT SIGNATURE_____ DATE: _____

Guardian Signature, if under 18 yrs: _____ DATE: _____