CLIENT IN-TAKE FORM

Please print clearly. In cases of multiple choice, please circle all that apply.

Name_____ Email _____

Phone numbers: Day _____ Eve._____

How did you hear about Eye Street Massage?_____

☐ ***Yes! Please add me to the email list to receive notifications about events & promotions. Otherwise I will only receive emails for appointment transactions like confirmations/reminders/receipts.***

☐ ***Yes! Please add me to your <u>text message list</u> so that I can be notified of events & promotions.***

Address_____ City/St/Zip _____

Age_____ D.O.B. _____ M / F / Non binary Height _____Weight_____

*Emergency contact name & number _____

Are you allergic to any skin products, detergents or smells? _____

Are you pregnant? Yes/No Trimester: 1st/2nd/3rd Due date: _____ Any health concerns? Yes/No

Have you previously received massage? Yes many times / Yes a little / No first massage ever

Have you previously received Reiki?

What is your primary goal for treatment right now? __ Rest/Relax __ Reduce Stress __ Chronic Pain __ Acute Pain or Injury __ Other _____

Preferred massage pressure: Light/Average/Deep /I'd like to discuss my pain threshold with you

How do you use your body in daily life? (occupation, caretaking, hobbies, exercise, etc.):

_____

What is your primary form of transportation: car / bike / foot / metro. Hours per day ____

Are there other physical demands on your body? _____

Describe what you do that helps you stay healthy? (exercise, diet, self-care, wellness practices, etc.) _____

What is your major area of pain or concern?_____

_____

When did you first notice it? _____ What brought it on? _____

What activities aggravate it? _____

Is this condition getting worse? Yes/No Does it interfere with work / sleep / recreation? (Circle)

What have you done to get relief? _____

Has there been a medical diagnosis? _____

By whom? _____

Are you presently under a doctor's care for any other condition? Yes/No

If yes, for what condition? _____

Physician's name & facility: _____ Phone_____

Please list medications you are currently taking (including non-prescription painkillers) & their purpose. Insulin / Blood thinners / Pain pills type _____

Car accidents or other injuries that may affect the massage _____

Broken bones _____

Surgeries _____

Do you have a history of: (please check all that apply)
Anemia/bruise easily Autoimmune disorders
Arthritis/bursitis
Blood pressure high/low
Blood clots/DVT
Cancer
Carpal Tunnel Syndrome
Depression/Anxiety
Diabetes
Dizziness/loss of balance
Epilepsy or seizures
Heart condition
Immune deficiency
Insomnia/sleep disorder
Joint injury/dislocation/surgery/replacement
Migraines/headaches
Numb or tingling feet
Number or tingling hands
Have a Pacemaker
Pinched nerves
PTSD or trauma
Plantar fascitis
Shooting pains
Skin disorders/rashes
Spinal or disk injuries or surgery
Tendonitis
Thoracic outlet syndrome
TMJD or teeth grinding/clenching
Varicose veins
Whiplash or neck injury
Other medical concerns?
Are there aspects of your health history you'd like to share? _____

- I hereby certify that I have filled out this form as accurately as possible, and I take sole responsibility to advise the therapist giving me the massage as to how it feels, favorably or adversely, and full responsibility to the results. This consent to treatment is intended to cover the entire course of care from all providers in this office for my present condition and for future conditions for which I seek care from this office.
- If I do not give **24 hours notice** for cancellation, I will pay the cancellation fee which is the full price of the massage.

Client's signature _____ Date _____

Therapist's signature _____ Date _____

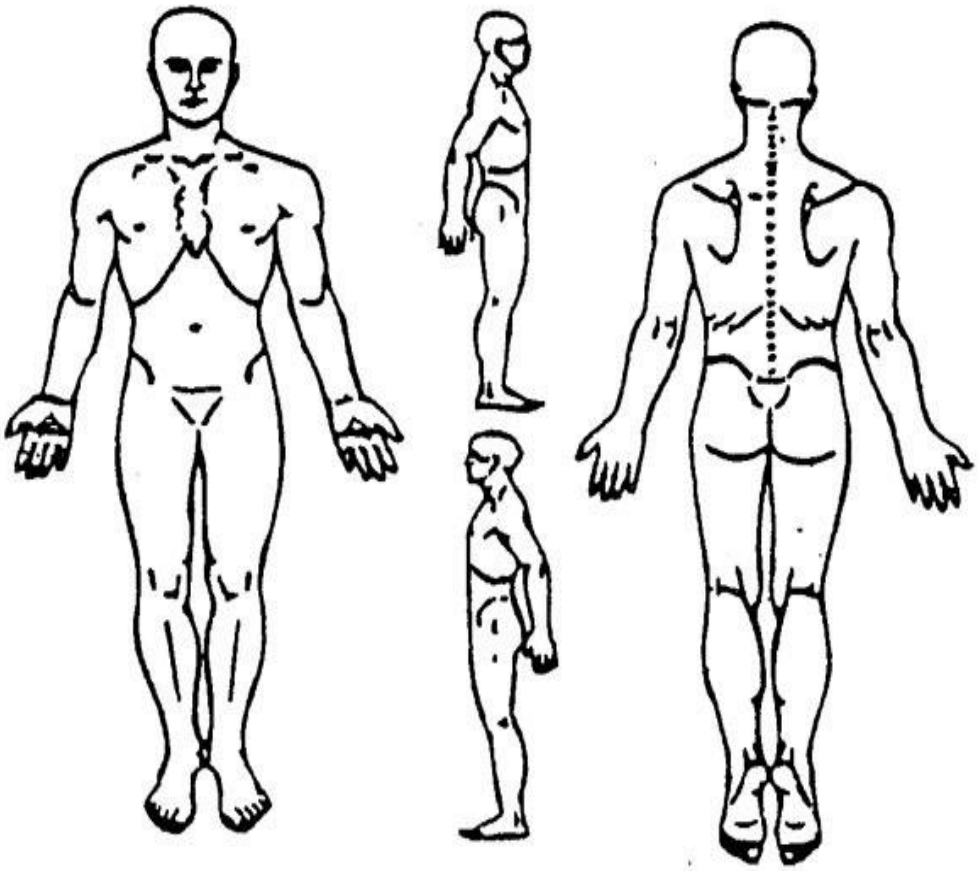
PLEASE COMPLETE THE NEXT PAGE

Client Name: _____

Please indicate areas of pain or tension on the figures below.
The symbols listed will allow you to be more specific:

Pain	+++	Numbness	- - - -	Tension	////

R L L R



Notes:

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