Total Body Wellness
Client Intake Form

Date: ______________________________
Name: ____
Address: ____
City:__________________State:______________Zip:________________________________
Home/Cell phone# (   )_______________Work phone#(   )___________________
E-mail Address: ______________________________Date of Birth: __________________
What is the best way to contact you?____
Occupation:__________________________ Emergency Contact:___________________
Relationship:__________________ Emergency Phone#(   )______________________

Who can I thank for referring you? ____

What goals/changes do you wish to reach with Therapeutic Bodywork?

____

____

Present Symptoms: What is your major complaint or condition you would like to improve? ____

Are you currently under the care of an M.D. or other health care provider? Yes / No

Name: _______________________Phone #(   )_________________________________

Are you currently taking any medication (including aspirin) or nutritional supplementation?
Yes / No
If yes, Please list: ____
Please list all conditions that you are using medication to treat:

____

Are your meds or supplements on maintained dosage?_________________________
Do you have any food or drug allergies? _______If so, to what?_________________
Do you drink water daily?_______ How much?__________ Smoke?_______________

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Client Intake Form (page 2)

Please list all current activities:

____

____

Would you be interested in pilates if you thought it may benefit you?

____

Health History
Please check the following conditions that apply to you, past and present. Be sure to include whether the condition is on the right, left or both sides of your body. Any further comments or clarifications are welcome. This will allow me make the best possible treatment plan for you.

Headaches
Migraines
Joint stiffness/swelling
Spasms/cramps
Broken/fractured bones
Strains/sprains
Dislocated joints
Back, hip pain
Shoulder, neck, arm, hand pain
Fibromyalgia
Leg, foot pain
Plantar fasciaitis
Chest, rib, abdominal pain
TMJ disorder
Sciatica
Tendonitis
Bursitis

Arthritis
Osteoporosis
Scoliosis
Skin rashes
Skin allergies/sensitivities
Multiple Sclerosis
Numbness/Tingling in limbs
Paralysis
interrupted sleep/insomnia
Ulsers
Herpes/shingles
Depression
Fatigue
Pregnancy (current or previous)
Menopause
Hysterectomy
Other:____________

Please note:
I am a professional massage therapy practitioner licensed by the State of Colorado. No areas of your body will be touched with out intent to professionally treat that area. As a Licensed Massage Therapist it is out of my scope of practice to diagnose any condition. If there is any need for diagnosis of any sort, I will refer you to your current medical provider and will communicate with that provider on how to proceed with treatment.

Cancellation Policy:
There is a 24 hour cancellation policy. All appointments canceled less than 24 hours prior to your scheduled appointment time are expected to be paid in full. Thank you for being mindful of that.

I (the client) have stated all conditions that I am aware of and all of the above information is true and accurate. I will inform my health care provider of any changes in my status.

Client Signature ________________________________**Date:**__________________