Bodywork Client Intake — page 1

Name ____ Date ________

Date Of Birth: ______________ Age:________ Sex: __________

Address:______________________________ City:______________ State:_______ Zip: ________

Phone: (home)_ ______________ (Work)________________

Occupation_________________________________ SS#________________

Insurance Co.______________________ Date of Injury __________ Claim #______________

Referred by________________________

What is the main reason for this visit?____

Have you received massage before?_____Yes ___No Frequency (if yes): ______________

likes: ____

dislikes: ____

Please list all accidents, injuries or surgeries and the date of each:

X ____

____

____

____

____

____

Are you receiving medical treatment?_____Yes____No

If yes, please give practitioner name, title and reason:

____

____

____

Are you taking any medication? ___ Yes___No

If yes, please explain:

____

____

____

Do you wear contact lenses?_____Yes____No

Are you currently experiencing any of the following conditions/symptoms:

____heart trouble	____inflammation	____allergies	___ pregnancy
____varicose veins	____infection	____skin conditions	___ menstrual problems
____high blood pressure	____broken bones	____rashes	___ HIV positive
____cancer	____sciatica	____fever	___ sleep difficulties
____MS	____numbness/tingling	____diarrhea	___ chronic fatigue
____diabetes	____arthritis	____constipation	___ intense stress
____epilepsy/seizures	____bursitis/tendonitis	____herpes virus	___ headaches
____contagious disease	____disc problems	___ cold or flu	___ other

Please explain:

____

____

Habits:	heavy	moderate	light	none
Alcohol	____	____	____	____
Coffee	____	____	____	____
Tea	____	____	____	____
Tobacco	____	____	____	____
Sugar	____	____	____	____
Water	____	____	____	____
Exercise	____	____	____	____

Chief complaints: ____

____

____

____

____

____

Where do you tend to hold stress in your body?

____

____

____

Postural/movement observations (therapist to fill in):

____

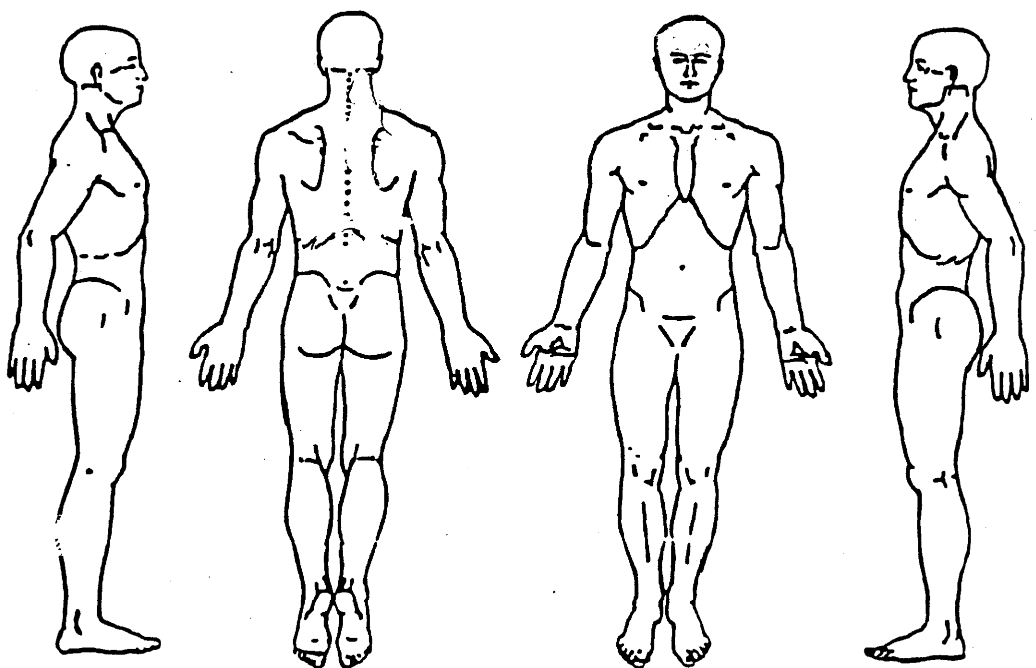
____

____

What aggravates your condition? ______________________________

____

Please indicate your areas of pain, tenderness, tension, etc. on the figures below:



I acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information for medical or insurance purposes. I authorize Brian Dobbs LMT to obtain any information from my primary health care providers concerning my health. I understand that the treatments are my personal financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made. I also understand that I will be charged for any appointment broken with less than 24 hours notice.

Signature ______________________________ *Date* ______________