Advanced Health Therapy Center

DISCOVER THE POWER OF WELLNESS

Confidential Client Intake Form

Name:_____ Birth Date:_____

Address:_____ Home Phone:_____

City/ST/Zip:_____/___/_____ Cell Phone:_____

E-mail:_____ Work Phone:_____

Occupation:_____ Employer:_____

Have you received Massage Therapy or Bodywork before?_____ How often?:_____ Marital Status:_____

Referred by?_____

Please check off any of the following which apply to you now or in the past:

___Stress	___Shoulder pain	___Bursitis	___Cancer	___Constipation	___Skin disorder
___Diabetes	___Varicose veins	___Allergies	___Asthma	___Severe depression	___Circulatory Problems
___Sinusits	___Edema	___Chest pain	___Blood clots	___Herniated disc	___Shortness of breath
___PMS	___Neck pain	___Dizziness	___Arthritis	___Heart condition	___High blood pressure
___Fatigue	___Ringing in ears	___Insomnia	___Sciatica	___Headaches	___Stomach disorders
___TMJ	___Fainting spells	___Hepatitis	___Back pain	___Loss of balance	___Pregnant (now)
___Lupus	___Fibromyalgia	___Multiple Sclerosis	___Other_____		

If you checked any above please explain here:_____

_____

_____

_____

Are you wearing contact lenses? Yes No

Have you had any operations or traumatic incidents/accidents in the past 3 years? Yes NO

If so explain:_____

Do you have tension pain or soreness today? Yes No

Do you: Stretch ___Drink water ___Use nicotine products ___Exercise ___ Consume Alcohol ___Caffeine ___Sugar____

Please list medications and purpose:_____

Are there any problems not listed that we should know about?_____

Major Complaints in order of importance to you:

_____ Since?_____ Cause?_____

_____ Since?_____ Cause?_____

_____ Since?_____ Cause?_____

OVER

More on Back

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER PHYSICIANS?

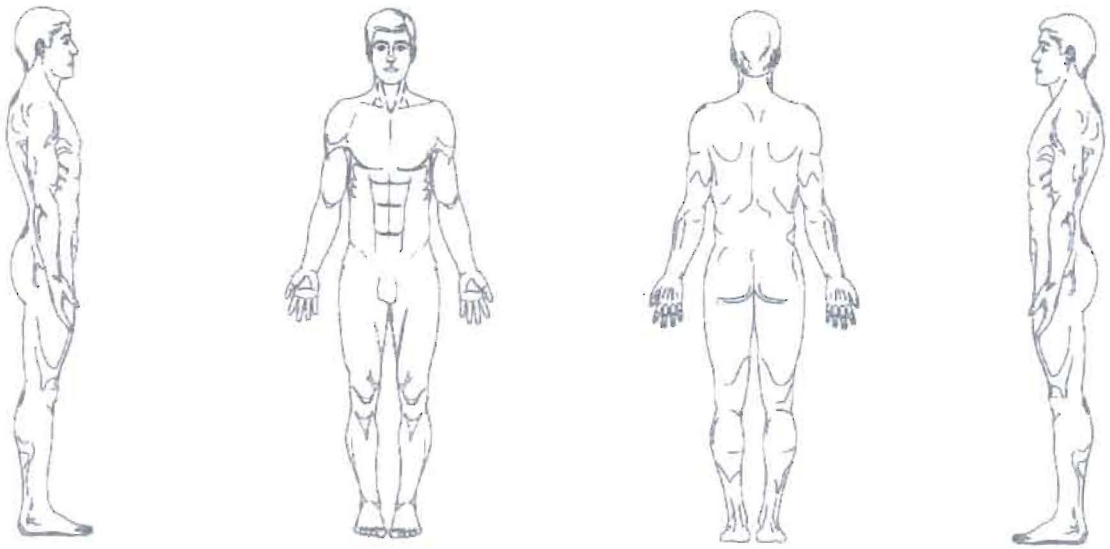
Dr. For: Treatment:

Dr. For: Treatment:

I have read and signed the consent form of ADVANCED HEALTH THERAPY CENTER, and stated all conditions that I am aware of and this information is true and accurate. I will inform the massage therapist of any changes in my health status before my next massage. I understand that I am responsible for providing medical information to my massage therapist. The massage therapist has reviewed this information and has explained the draping procedures and the general techniques he intends to use. I understand that if at any time I am uncomfortable with the massage or any technique being used I can ask the therapist to stop, change techniques, or to end the massage.
Barring an emergency, I understand that 24 hour cancellation is required or the session fee will be paid in full.

Signed:_____ Date:___/___/_____

Please mark areas of tension, stress or pain you are experiencing on the figures below



Any additional information about you the therapist should know: