# THERAPEUTIC MASSAGE

Confidential Client Intake Form

Today's date _______________

Thank you for taking the time to complete the following information which will help me assess your health needs. You can be as brief or thorough as you like. All information is confidential.

## General Information

Name__________________________________Birthdate___/___/____

Address________________________________City_________________

State________Zip_______ Phone(s)__________________________________________

E-mail address________________________________________

Would you like to receive our e-newsletter with supportive health information ? □ Y □ N

Your Occupation ______________________hrs per week_______

Referred by ___________________________________________________

Primary Care: Name _____________________________ Phone Number_________________

## Emergency Contact

Name_____________________________Ph____________________ Relationship_________________

## Lifestyle

Do you exercise? If so what type and how many times a week_______________________________

How many hours of sleep per night do you normally receive: < 4 4-6 7-8 8+

What is your normal daily intake of water_____ caffeine_____ alcohol_____

Have you ever received a professional massage? □ Yes □ No If yes frequency/type_________________

What are your goals for your health?

_____________________________________________________________________________________

Are you currently in pain or experiencing discomfort? If so please explain and indicate those areas:

__________________________________________

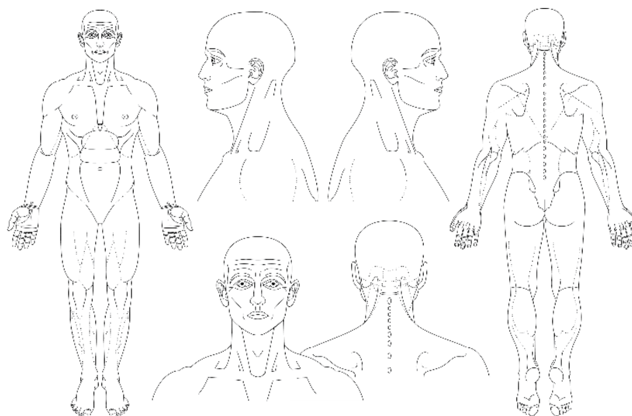
__________________________________________

What makes it better_____________________

__________________________________________

What makes it worse_____________________

__________________________________________



# Health History

Please check any condition listed below that applies to you:

☐ family ☐ past ☐ present

☐ ☐ ☐ Alcoholism
☐ ☐ ☐ Allergies______
☐ ☐ ☐ Anxiety
☐ ☐ ☐ Arthritis
☐ ☐ ☐ Asthma
☐ ☐ ☐ Bleeding disorder
☐ ☐ ☐ Blood clots/ disease
☐ ☐ ☐ Cancer or tumor
☐ ☐ ☐ Depression
☐ ☐ ☐ Diabetes
☐ ☐ ☐ Emphysema
☐ ☐ ☐ Eating disorder
☐ ☐ ☐ Fibromyalgia
☐ ☐ ☐ Heart disease

☐ family ☐ past ☐ present

☐ ☐ ☐ Hepatitis
☐ ☐ ☐ Herpes
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ HIV/AIDS
☐ ☐ ☐ Immune disorder
☐ ☐ ☐ Joint replacement
☐ ☐ ☐ Kidney disorder
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Lyme's disease
☐ ☐ ☐ Lymph nodes removed
☐ ☐ ☐ Multiple Sclerosis
☐ ☐ ☐ Pacemaker
☐ ☐ ☐ Polio
☐ ☐ ☐ Rheumatic arthritis

☐ family ☐ past ☐ present

☐ ☐ ☐ Rheumatic fever
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Scarlet fever
☐ ☐ ☐ Seizures/Epilepsy
☐ ☐ ☐ Sinus infections
☐ ☐ ☐ Skin disease
☐ ☐ ☐ Special diet
☐ ☐ ☐ Stroke
☐ ☐ ☐ Substance abuse
☐ ☐ ☐ Thyroid disease
☐ ☐ ☐ Tuberculosis
☐ ☐ ☐ Ulcer
☐ ☐ ☐ Venereal Disease/STD
☐ ☐ ☐ Other________

List any accidents, injuries, surgeries, or hospitalizations you have had and the year they occurred:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Medications, Herbs, Supplements (List those you are currently taking):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

# Traditional Chinese Medicine

5 Element Checklist

Please check the following that currently pertain to you

**Liver/Gallbladder**

☐ Depression / Stress
☐ Headaches / Migraines
☐ Red / Dry / Itchy Eyes
☐ Visual Problems / Blurred Vision
☐ Dizziness
☐ Gall Stones
☐ Feeling of Lump in Throat
☐ Clenching Teeth at Night
☐ Muscle Cramping / Twitching
☐ Neck/Shoulder Pain / Tightness
☐ Seizures/Tremors
☐ Poor Circulation
☐ Soft/Brittle Nails
☐ Bitter Taste in Mouth
☐ PMS/Menstrual Problems
☐ Tendonitis
☐ Pain Below Ribcage
☐ Do you crave: Sour
☐ Tend to be Irritable / Angry

**Heart/Small Intestine**

☐ Heart Palpitations
☐ Rapid or Irregular Heartbeat
☐ Chest Pain
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Insomnia / Sleep Problems
☐ Vivid Dreams / Nightmares
☐ Easily Startled
☐ Dark Urine
☐ Red Complexion
☐ Do you crave: Bitter
☐ Anxiety / Nervous or Restless

**Spleen/Stomach**

☐ Body Heaviness
☐ Hard to get up in Morning
☐ Muscles Often Feel Tired
Energy Level: 1-10 (low to high)
☐ Edema (☐ Hands ☐ Feet)
☐ Easily Bruising / Bleeding
☐ Bad Breath
☐ Sweetish Taste in Mouth
☐ Lack of Taste
☐ Excess or Low Appetite (circle which)
☐ Excess or Lack of Thirst (circle which)
☐ Nausea / Vomiting
☐ Gas / Belching
☐ Hemorrhoids
☐ Organ Prolapse (i.e. uterus)
☐ Chronic Loose Stools
☐ Abdominal Pain
☐ Indigestion / Heartburn
☐ Brain Foggy
☐ Mouth Ulcers
☐ Tendency to Gain Weight
☐ Do you crave: Sweet
☐ Over-thinking / Worry

**Lung/Large Intestine**

☐ Bloody Cough
☐ Dry Cough
☐ Chronic Cough
☐ Cough with Sputum
☐ Nasal Discharge
☐ White ☐ Yellow ☐ Green
☐ Post Nasal Drip
☐ Sinus Infection / Congestion
☐ Itchy, Red, or Painful Throat
☐ Dry Mouth / Nose / Throat
☐ Skin Rashes / Hives
☐ Snoring
☐ Shortness of Breath
☐ Allergies / Asthma
☐ Low Immunity
☐ Catch Colds Easily
☐ Bronchitis
☐ Black or Bloody Stools
☐ Constipation
☐ IBS
☐ Diarrhea
☐ Colitis / Spastic Colon
☐ Do you crave: Pungent / Spicy
☐ Grief / Sadness

**Kidney/Urinary Bladder**

☐ Urinary Problems (i.e. night-time)
☐ Bladder Infection
☐ Incontinence
☐ Weakness / Pain in Low Back
☐ Osteoporosis
☐ Feel Cold or Hot Easily (circle which)
☐ Cold Hands / Feet
☐ Dark Circles under Eyes
☐ Thyroid Problems
☐ Poor Memory
☐ Hair Loss / Grey Hair
☐ Hearing Problems / Tinnitus
☐ Cavities
☐ Hot Flashes / Night Sweats
☐ Do you crave: Salt
☐ Fear

## Cancellation Policy

In the event that you must cancel an appointment, please give us the courtesy of as much notice as you can, but at least 24 hours' notice. You will be charged the full fee for your session if you do not show up for your appointment.

## Late Policy

If you are going to be late, please call and let us know and we will wait until the time we agree upon. If you do not give notice, we will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the full payment of the session.

## Consent

It is my choice to receive massage therapy. I understand that massage therapists do not diagnose illness, disease or any physical or mental disorder; does not prescribe medical treatment pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. If deemed necessary, I give consent to my massage therapist to contact my primary care physician or health care provider. I realize that massage is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm, or pain or for increasing circulation or energy flow. I have state all medical conditions that I am aware and will update my massage therapist of any changes in my health status. I agree to communicate with my massage therapist any time I feel my well-being is being compromised. My massage therapist reserves the right to refuse services for reason of safety and in the event of a client's needs exceeding the therapist's knowledge, skills, or abilities.

## Agreement

I have read and understood the Rejuvenate policies. I agree to all the above treatment terms and conditions.

Signature: ________________________________

Date: _________________