Client Intake Form

Date_____ Email Address _____

Name_____ How do you prefer to be addressed? _____

Address_____City_____ State_____ Zip Code_____

Telephone: (home) _____ (work): _____

Birth Date_____ Height_____ Weight_____

Occupation_____ Are you currently working? _____ Hours per week_____

How did you hear about us?_____ Referred by_____

THE FOLLOWING IS VERY IMPORTANT IN OUR CLINICAL ASSESSMENT. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT CONDITION AND SYMPTOMS.

1. **What is your primary complaint** Please describe your symptoms as specifically as possible.

2. **On what date did your symptoms begin?** _____

3. **How did your symptoms begin?** For example, did your symptoms begin as a result of an accident of trauma, or did they begin without a known reason?

4. Do you have any of the following medical conditions?

	YES	NO		YES	NO
Circulatory problems	____	____	**Stroke**	____	____
Blood clots	____	____	**Blackouts**	____	____
High blood pressure	____	____	**Visual disturbances**	____	____
Heart trouble	____	____	**Weight Changes (>15lbs.)**	____	____
Pacemaker	____	____	**Headaches**	____	____
Epilepsy	____	____	**Ringing in ears**	____	____
Diabetes	____	____	**Bowel/Bladder Problems**	____	____
Pregnancy	____	____	**Malignancy**	____	____
Communicable disease	____	____	Other	____	____

5. **Past Medical History:** Please list any surgeries, traumas, accidents or other conditions along with the dates.

6. **Have you ever had a professional massage? Yes/No Have you ever received Myofascial Release? Yes/No**

7. **WHAT ARE YOUR TREATMENT GOALS?**

Massage Therapy/Bodywork Waiver

I, _____, understand that the massage therapy/bodywork given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. I understand that massage therapy/bodywork is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical, mental and emotional health.

SIGNATURE: _____ Date _____

WITNESS: _____ Date _____

DAILY PROGRESS NOTE

PATIENT NAME: _____ **DATE:** ____/____/____

PATIENT'S DESCRIPTION OF CURRENT CONDITION:

_____

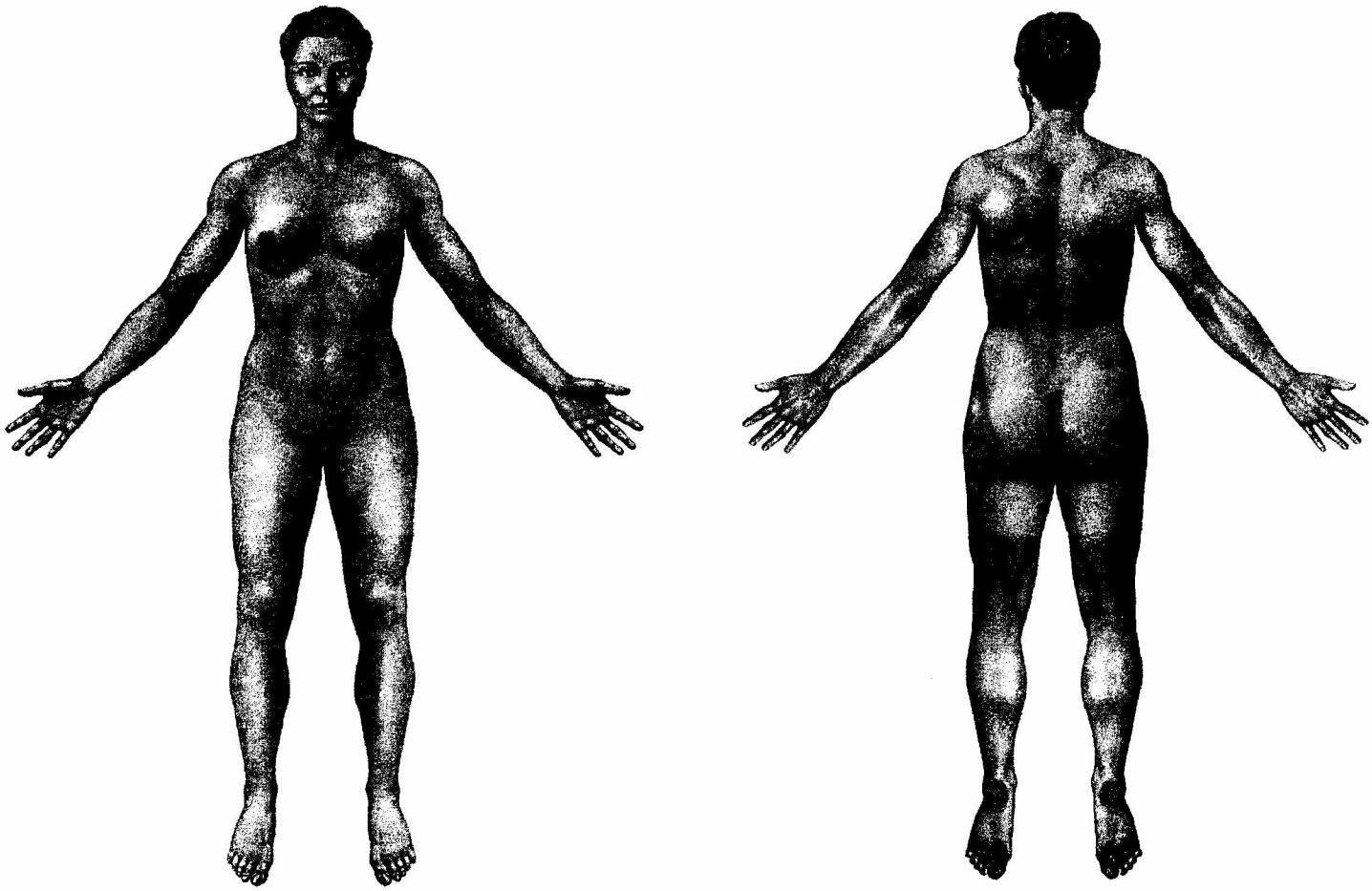
_____

_____

_____

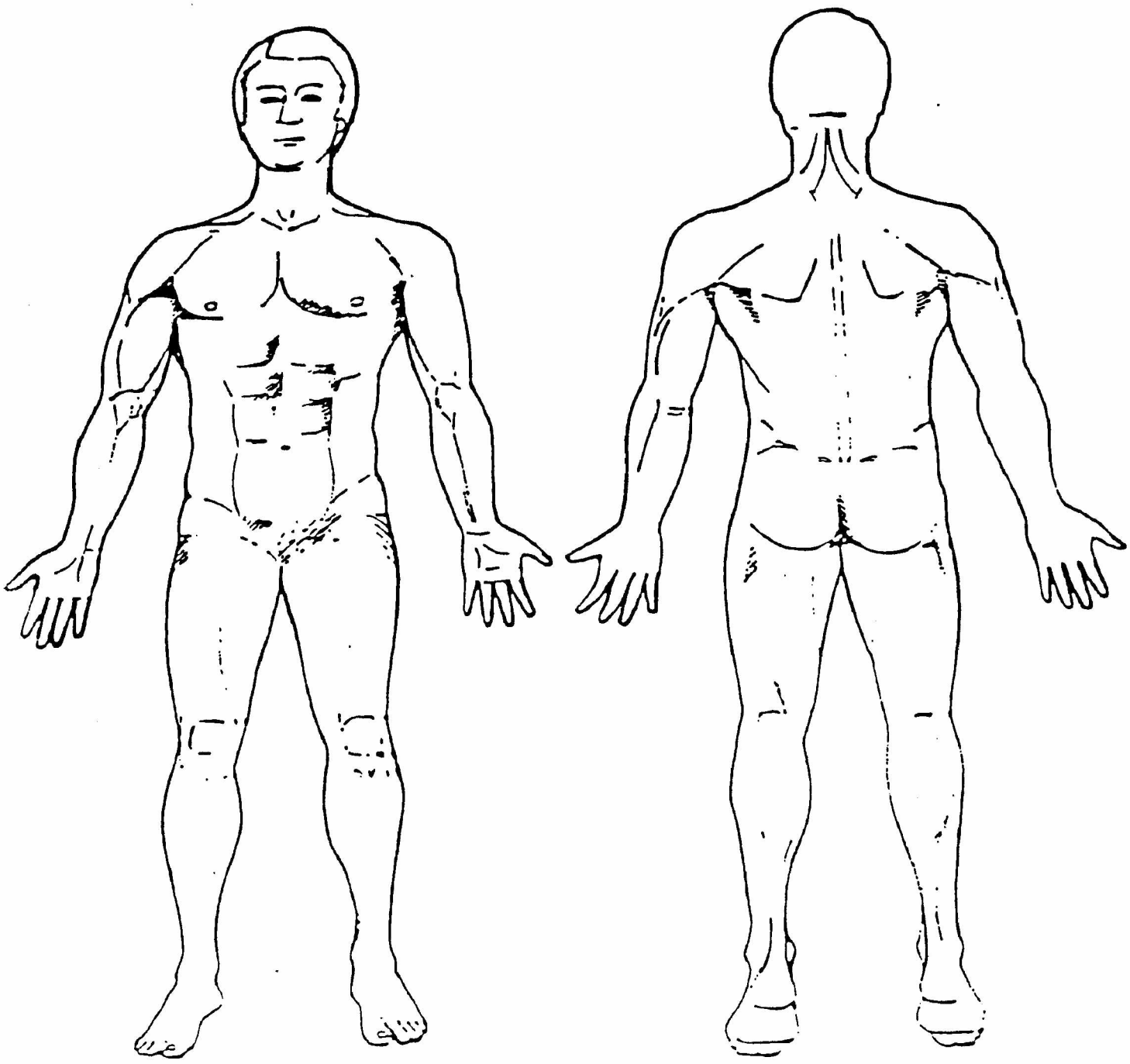
PLEASE INDICATE SYMPTOM AREAS ON THESE DIAGRAMS AND RATE THE INTENSITY OF EACH AREA USING THE FOLLOWING SCALE:

	NONE		MILD		MODERATE				SEVERE		
PAIN LEVEL	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**



PATIENT SIGNATURE: _____

PLEASE SHADE AREAS OF PAIN ON THE DIAGRAM BELOW:



PLEASE PLACE A ✓ IN FRONT OF EACH ITEM THAT YOU EXPERIENCE AT LEAST MONTHLY. PLACE AN X IN FRONT OF EACH ITEM THAT YOU EXPERIENCE WEEKLY OR MORE FREQUENTLY.

___ Headaches (type)
___ Heart pounding or racing
___ Irregular heart beat
___ Chest pain, tightness
___ Numbness, tingling in arm or leg
___ Can't keep warm enough
___ Sweaty palms
___ Blushing, flushing face
___ Coughing
___ Stuffy nose, congestion
___ Earache or ringing noise in ears
___ Common colds
___ Sore throat
___ Asthma or shortness of breath
___ Hay fever or allergies
___ Sore, aching muscles
___ Stiff or tender joints
___ Back problems
___ Trembling / twitching muscles
___ Skin rashes, eruptions
___ Grinding of teeth (TMJ)
___ Dry mouth
___ Mouth sores
___ Excessive perspiration
___ Difficulty falling asleep
___ Difficulty sleeping through night
___ Awaken too early in morning
___ Excessive drowsiness during day
___ Periods of extreme fatigue
___ Feeling faint or dizzy
___ Feeling tense or nervous
___ Difficulties with family or friends
___ Worrisome thoughts
___ Recurring bad thoughts
___ Thoughts of suicide
___ Fearful of persons or places

___ Felling inadequate / unable to cope
___ Feeling guilt or failure
___ Uncontrolled crying or sadness
___ Easily annoyed or irritated
___ Free-floating anxiety about life
___ Voice quivering, shaking
___ Eyes irritated or inflamed
___ Vision blurred
___ Eyestrain or discomfort
___ Nosebleeds
___ Stomach cramps
___ Heartburn - indigestion
___ Nausea or vomitting
___ Frequent urination
___ Incomplete urination
___ Painful urination
___ Urinary leakage
___ Bowel leakage
___ Gas in lower bowel
___ Diarrhea
___ Constipation
___ Bowel irregularity
___ Uninterested in sex relations
___ Unable to enjoy sexual activity
___ Unable to participate in sex acts
___ Menstrual difficulties
___ Pre-menstrual Syndrome
___ Breast tenderness
___ Hot Flashes
___ Water retention
___ Over-eating, bingeing
___ Lack of appetite
___ Excessive alcohol abuse
___ Other substance abuse
___ Frequent laxative use
___ Other:

MEDICATIONS:

Please indicate below ALL medications which you are currently taking, the problem for which you are using them and the dose and their effectiveness:

Medication:	For Treatment of:	Dose / Amt / Day:	Effectiveness:

HeartSong Healing Arts LLC

This massage/ mfr treatment is strictly therapeutic and completely non-sexual. Any sexual advances on my part will immediately result in the termination of the session and I will be responsible for full payment. Payment is due at completion of session. I agree to pay for all scheduled appointments that I am unable to keep unless I have notified the therapist within 24 hours of the scheduled session.

Client's signature_____

Date_____