New Client Intake Form

CONFIDENTIAL CASE HISTORY

To ensure the best professional care and therapeutic treatment, please take a few minutes to complete the following information.

PERSONAL INFORMATION

Today's Date:_____
Last Name:_____First Name:_____
Address:_____City:_____PostalCode:_____
Home Phone:_____Cell Phone:_____Email:_____
Date of Birth (D/M/Y)_____
AB Health Care #: _____ Extended Health Care: Yes / No Provider: _____
Occupation_____Company _____
Emergency Contact_____ Phone_____
How did you hear about us?_____
Is this your first visit to a registered massage therapist? ☐YES ☐NO

MEDICAL INFORMATION

Are you under the care of a Physician? ☐Yes ☐No
If yes, please explain:
_____
_____

Are you currently pregnant? ☐Yes ☐No
If yes, how far along? _____
Any high risk factors? _____

Do you suffer from chronic pain? ☐Yes ☐No
If yes, please explain_____
What makes it better?_____

Have you had any orthopedic injuries? ☐Yes ☐No
If yes, please List:_____

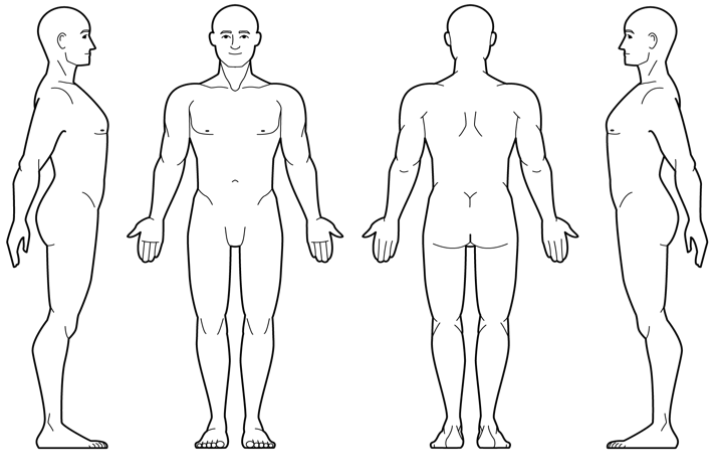
Please Indicate any of the following that apply to you:
☐ Cancer ☐ Headaches/Migraines ☐ Arthritis ☐ Diabetes
☐ Joint Replacement(s) ☐ High/Low Blood Pressure
☐ Neuropathy ☐ Fibromyalgia ☐ Stroke ☐ Heart Attack
☐ Kidney Dysfunction ☐ Blood Clots ☐ Numbness
☐Sprains or Strains

Explain any conditions you have marked above:
_____
_____
_____
_____

Do you:
☐ Smoke ☐ Vape Tabacco/Nictione?
If yes, How often: _____ Quantity: _____
Consume Alcohol: ☐ Yes ☐ No
if yes, How often: ____Quantity: _____
Exercise: ☐ Yes ☐ No if yes, How often: ____Quantity:____

MASSAGE INFORMATION

Have you had a professional massage before? ☐ Yes ☐ No
What type of massage are you seeking?
☐ Relaxation ☐ Therapeutic/Deep Tissue ☐Sport ☐Thai
☐ Cupping ☐ Other _____
What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep
Do you have any allergies or sensitivities? ☐ Yes ☐ No
Please explain _____
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No
Please explain _____
What are your goals for this treatment session?
☐ Relaxation/Wellbeing ☐ Stress/Tension
☐ Injury ☐ Pain Relief ☐ Motor Vehicle Accident
☐ Other _____
Is the pain:
☐ Constant ☐ Periodic ☐ Increasing ☐ Worse at night
☐ Shooting ☐ Dull ☐ Achy ☐ Stiffness ☐ Spsam
☐ Weakness ☐ Tingling ☐ Throbbing ☐ Burning
Plase circle any areas of discomfort



Consent to perform Massage Therapy

I, _____ understand that the massage therapy provided is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive health experience.

The general effects of massage, contraindications as well as the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I currently work with my primary care giver for any conditions I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications. I will keep the therapist updates of any changes.

By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Massage Therapy
KHAN KRISTIANSON