Client Intake Form

Last Name ____________________________ First Name _____________________ Date of Birth (mm/dd/yyyy) ________________

Address ____ City/Prov ______________________ Postal Code _____________

Cell Phone ______________________ Email ____ (used for appointment reminders only)

Emergency Contact _______________________________ Phone __________________ Relationship _______________________

Doctor ____ Chiropractor ____

Occupation _________________________ How did you hear about us? ____

Do you have any allergies? (Oils, lotions, nuts, fruits, etc.) Yes No If yes, please list: ______________________________

Are you pregnant? Yes No If yes, how many months: ________ Due Date ____________________________

Are you currently under medical supervision or receiving other medical interventions? Yes No

If yes, please describe: ____

Any previous injuries? (falls, car accidents, sports injury, etc.) ____

Are you currently taking any medications? Yes No Please list ____

Have you had any previous surgeries? Yes No Please list ____

Any areas of broken skin? (rash, wounds, etc.) Yes No Please list ____

Please check any condition listed below that applies to you:

Areas of swelling	Diabetes	Osteoporosis
Autoimmune disorder	Fibromyalgia	Pins/Plates/Prosthesis
Back/neck problem	Headaches	Sciatica
Bleeding disorders	Heart condition	Seizures
Blood clots	Hypertension	Stroke
Bruise easily	Kidney Disease	Tendinitis
Bursitis	Multiple Sclerosis	TJM disorder
Cancer	Neurological condition	Varicose veins
Contagious condition	Neuropathy	Vertigo / dizziness
Decreased sensation	Osteoarthritis	

What is the primary location of your pain? ________________________________ Is it isolated or does it radiate? ______________

Please list any secondary areas of pain or discomfort ____

Have you had a professional massage before? Yes No If yes, how recently? _______________________________

Please rate your pain on a scale of 1-10 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

What typically helps relieve the condition? ____

What typically aggravates the condition? ____

Is there anything else in your health history that would be relevant for your massage practitioner to know in order to provide a safe & effective massage treatment plan for you? ____

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By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have disclosed all medical conditions and completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes. All information is confidential and patient case history forms remain property of Meridian Integrated Health and Wellness. Information can only be released with a signed written request from the client.
I give my consent for treatment and I'm aware results are not guaranteed. I agree to inform the therapist if I experience discomfort. I consent that during the course of my treatment, certain areas of the body may be treated if clinically indicated such as: chest wall muscles, gluteal region, upper inner thigh, anterior pelvic region or groin area. I also agree to stop the session if I feel my well-being is compromised in any way.

Client Name ________________________________

Client Signature ____ Date ___________________________

Payment is expected at the time service is rendered. If cancellation is necessary, please give 24 hours' notice, otherwise you will be charged for the appointment. Emergency cancellations or missed appointments are determined at the therapist's discretion.

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