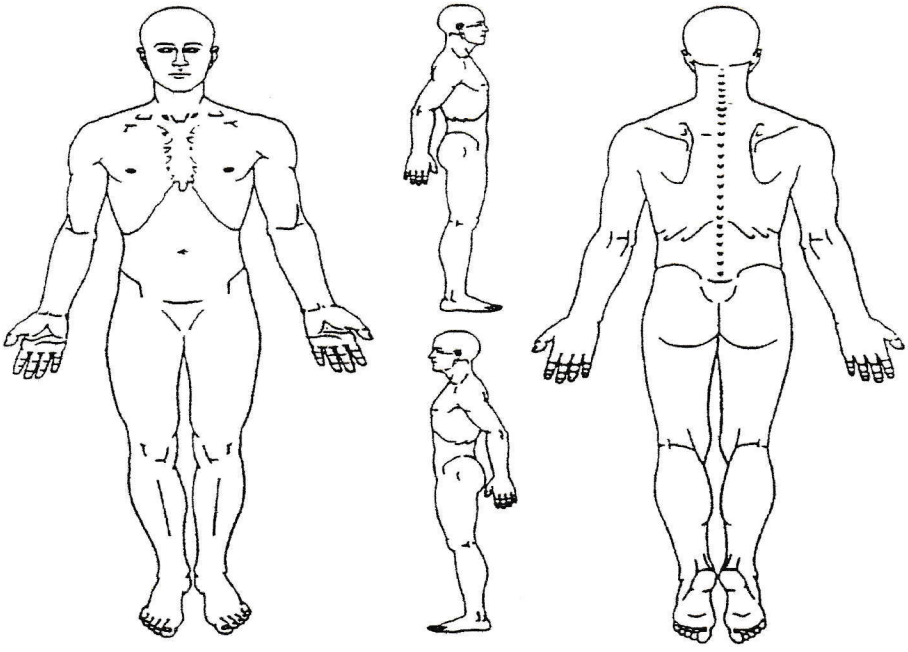
New Client Intake Form

Name:_____ Date:_____ Referred By:_____
Email:_____ Phone - Mobile:_____
Address:_____ Phone - Home:_____
City/State/Zip:_____ Birthday:_____ Occupation:_____
Emergency Contact:_____ Emergency Contact Phone:_____

- **General Information:**

What is your main reason for coming to therapy?_____
What specific goals would you like to achieve from therapy?_____
_____
How and when did the symptoms begin?_____
Where are your symptoms located? Please mark on the diagram below where your symptoms are located:



Describe the symptoms. Circle all that apply:

Dull Ache Burning Sharp Periodic Constant Sore Stiff Numb Tingling

How long have you had these symptoms?_____
On a scale of 0 to 10, with 10 being most severe imaginable discomfort, what is your discomfort level?

0 1 2 3 4 5 6 7 8 9 10

What makes it better or worse?_____
What time of day is the pain worse?_____
Do you have trouble sleeping? YES / NO If yes, what position do you sleep?_____
Are you currently, or have you ever been , under medical supervision for this problem? YES / NO
explain:_____
Have you had any tests for this problem; such as X-rays, MRI, CT scans? YES / NO
Please list:_____
What physical activities are you involved in?_____

Have you experienced any kind of bodywork before? (i.e. massage, acupuncture, FST, etc.)? YES / NO
If yes, what type?_____How often?_____With whom?_____
Do you wear any type of supportive brace? YES / NO
If yes, what type?_____ Where?_____ How often?_____
Do you wear orthotics? YES / NO If yes, for how long?_____
Are your symptoms worse at the end of the workday? YES / NO
Does your work station give you support and encourage good posture?_____
How would you rate your own posture?_____

- **Medical History:**

Please list any recent injuries, illnesses, or surgeries:_____
_____
Are you currently under the care of a physician? YES / NO
If yes, please explain:_____
_____
Please list any medications you are currently taking:_____
_____
Circle all that apply:

Cancer: Type:_____	Hi/Low Blood Pressure	Epilepsy	Digestion Problems
Respiratory Problems	Heart Problems	Allergies	Sinus Problems
Elimination Problems	Cold Hand/Feet	TMJ	Back Problems
Migraines/Headaches	Neck Problems	Sciatica	Bruise Easily
Arthritis/Bursitis	Fibromyalgia	Stroke	Carpal Tunnel
Immovable Joints	Osteoporosis	Asthma	Diabetes
Scoliosis	Immune Disorder	Tendonitis	Ulcers
Cold Hands/Feet	Stroke	Pregnant: How long?_____	

Do you have chronic or frequent pain? YES / NO Have you ever had a head injury? YES / NO
Have you noticed dizziness? YES / NO Change in hearing? YES / NO
Change in vision? YES / NO
Have you had any major surgeries? YES / NO If yes, eplain_____
_____
Have you had any accidents? YES / NO
If yes, explain_____
_____
Are there any other medical conditions the therapist should be aware of? YES / NO
Describe:_____
_____

- The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the therapist of my condition. I understand that this office and it's therapists do not diagnose or treat illness or disease and do not prescribe medications. I agree to pay my account with this office in accordance with the regular rates and payment terms. If, for any reason cancellation is necessary, I will give 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment. Emergency cancellations will be determined by owner. It is agreed that any claim of liability is hereby waived.

Signature:_____Date:_____

Massage Therapy Informed Consent

I, _____(Client) understand that massage therapy provided by Brigitte Papp, LMT, BCTMB, (Massage Therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____

_____

_____

The general benefits of massage, possible massage contraindications, and 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 concurrently work with my Primary Caregiver for any condition 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, medications , and I will keep the Massage Therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

I have received a copy of the therapist's policies, I understand them and agree to abide by them.

Client Signature: _____ Date:_____