

**Natural Health Camden
Client Health Intake Form**

**Please fill out completely and sign.
General Contact Information**

Name _____ **Date** _____

Address _____

City/State _____ **Zip** _____

Daytime phone _____ **Evening phone** _____

Cell phone _____ **E-mail address** _____

Occupation _____ **Birth date/age** _____

How did you hear about us? **Friend** _____ **Other** _____

Have you had a professional massage before? Yes No **Did you enjoy the experience** _____

Type of massage experienced (swedish, shiatsu, deep tissue, etc.) _____

Current Health

Where are you currently feeling pain or tension? _____

Do you have limited range of motion? Where? _____

Do you have other concerns your massage therapist should be aware of? _____

What exercise do you regularly perform? _____

Do you have allergies or sensitivity to oils lotions scents _____

Are you pregnant? No Yes, What week? _____ **Any Challenges?** _____

Who is your OB? _____ **Have you spoken to them about receiving massage?** Y/N

Medical History

Are you currently under a doctor or therapist's care? Yes No

If yes, for what? _____

Please describe any injuries or surgeries in the past 5 years _____

Please check any of the following conditions you have now or have had in the past

- Allergies
- Asthma
- Blood clots
- Breathing Problems
- Broken/fractured bones
- Cancer
specify primary site _____
- Diabetes
- Edema (swelling)
- Fibromyalgia
- Headaches
- Heart disease/attack

- High/low blood pressure
- Jaw pain (TMJ)
- Lymph node removal
specify location _____
- Numbness
- Osteoarthritis
- Osteoporosis/osteopenia
- Rheumatoid arthritis
- Sciatica
- Skin disorders
- Slipped/degenerative/
fused disc

- Tendon/ligament/ tear
- Varicose veins
- Other, please specify _____

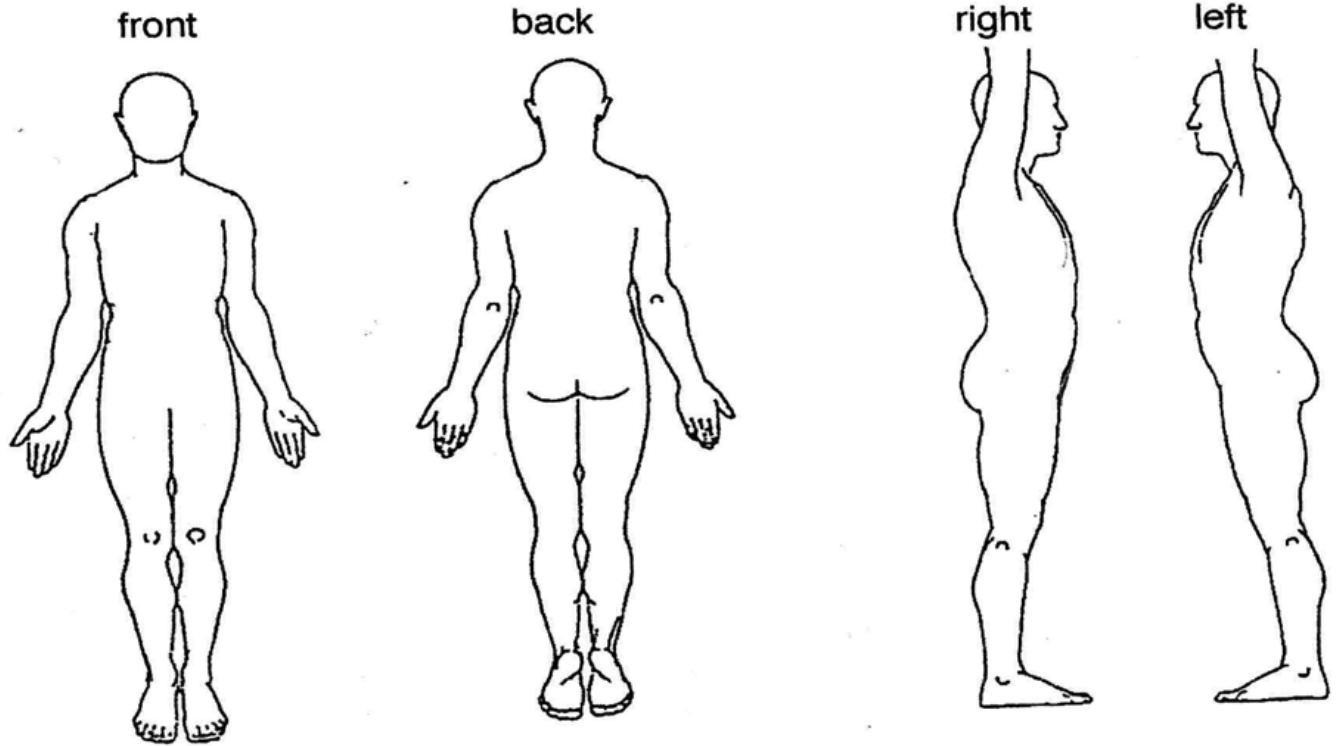
- Are you taking any of the following types of medication?
- Blood pressure meds
 - Blood thinner
 - Pain killers
 - Cortisone injection
 - Anti-inflammatories
 - Muscle relaxant

BODY MAP

Please complete the body map using the symbols below.

X – Areas I do NOT want massaged

O – Areas that need extra attention (pain, tension, or concern) F – Favorite Areas



What are your goals/expectations for this therapy session? _____

The following sometimes occurs during massage; these are a few of the normal responses to relaxation. Trust your body to express what it needs to: a need to move or change position * sighing * yawning * change in breathing * stomach gurgling * emotional feelings and/or expression * movement of intestinal gas * energy shifts * falling asleep * memories.

Cancellation Policy

Our time together is important. Unless you have an emergency, please cancel your appointment 24 hours in advance or pay the missed appointment fee in full.

RELEASE

Please read carefully and sign below.

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I also may request that the session be discontinued at any time, for any reason, and the therapist will honor that request. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully. I give my permission to have massage techniques applied to my person.

Signature _____ Date _____