Client Intake Form

NAME_____ PHONE#_____ DOB_____ TODAY'S DATE_____
ADDRESS_____ EMAIL_____
EMERGENCY CONTACT INFO._____ OCCUPATION_____
INSURANCE CARRIER_____ PRIMARY PHYSICIAN INFO._____

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? _____ WHEN WAS YOUR LAST TREATMENT? _____
ANY OTHER TREATMENTS RECEIVED? ACUPUNCTURE – CHIROPRACTIC – PHYSICAL THERAPY – NATUROPATHY – OTHER_____
_____

PLEASE MARK ANY CONDITIONS BELOW YOU HAVE EVER EXPERIENCED OR ARE CURRENTLY EXPERIENCING.

- ○ Allergies – Types _____
- ○ Frequently Suffer from Stress
- ○ Broken Bones – Specify _____
- ○ Injuries causing Chronic problems – Specify _____
- ○ Bruise Easily
- ○ Diabetes
- ○ Frequent Headaches – Specify _____
- ○ High or Low Blood Pressure
- ○ Taking Medications for Blood Pressure
- ○ Joint Swelling
- ○ Trouble Sleeping
- ○ Epilepsy or Seizures
- ○ Sensitive to Touch or Pressure in Any Area – Specify _____
- ○ Cancer - Cancer Treatments – Specify _____
- ○ Any Other Medical Conditions or Medications – Specify _____ _____
- ○ Tension or Soreness in a Specific Area – Specify _____
- ○ Pregnant
- ○ Varicose Veins – Deep Vein Thrombosis
- ○ Any Contagious Diseases – Specify _____
- ○ Osteoporosis
- ○ Arthritis
- ○ Rheumatoid Arthritis
- ○ Cardiac or Circulatory problems
- ○ Back Pain
- ○ Neck Pain
- ○ Shoulder Pain
- ○ Bone and/or Joint Degeneration
- ○ Fybromyalgia
- ○ Numbness, Tingling, or Stabbing Pains – Specify _____
- ○ Any Surgeries – Specify _____
- ○ Edema
- ○ Depression
- ○ Fatigue
- ○ Seasonal Affective Disorder
- ○ Digestive Problems

PLEASE READ CAREFULLY THE FOLLOWING DISCLAIMER AND SIGN WHERE INDICATED.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated, to the best of my knowledge, all my known medical conditions/history and answered all questions honestly. I understand that if I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the appropriate adjustment can be made for my comfort. I further understand that bodywork should not be construed as a substitute for medical examination or diagnosis, and that I should see a physician, chiropractor, or other qualified medial specialist for any mental or physical ailment of which I am aware. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the part of the practitioner, or the establishment of Epidavros Center for Wellbeing, should I fail to do so.

CLIENT SIGNATURE_____ TODAY'S DATE_____

Consent to Treatment of a Minor: By my signature below, I hereby authorize All Wellness Practitioners within Taylor Made Energetics to administer Bodywork, Massage, Energy Healing or other therapy techniques to my child or dependent as they deem necessary. I understand that the practitioner will keep me informed of any problems and/or improvements as they deem necessary, for said minor may need assistance and reassurance from me.

CLIENT SIGNATURE_____ TODAY'S DATE_____