New Client Health Intake Form

Clinic Name: ***Touch of Ascension Therapeutic Massage (Page 1 of 2)***

Client Contact Information:

Client Name: Today's Date:
Date of Birth: Gender: Male/Female

Address: City/State:

Phone: (Home) (Cell) (Work)

Occupation (If Employed):

Email Address:

Emergency Contact Person (Full Name & Phone Number):

- Please send me Appointment Reminders via Text Message. *Please Circle: Yes or No?*
- Please send me Appointment Reminders via Email. *Please Circle: Yes or No?*

How did you want to pay for your session today? ***Please Circle*** (Cash/Credit/Gift Certificate/Flex or Health Savings/Spending Card)

How did you hear about Touch of Ascension? ***Please Circle and/or List*** (Person/TOA Website/Thumbtack/Yelp/Search Engine/ Other)
Who Referred You if Person?

Physician/Health-Care Provider name: Phone:

Do you receive regular medical care either for yearly wellness checkups or for any particular medical condition? ***Yes or No?***
Do I have permission to contact your provider in terms of your care with me (***only if needed)?*** ***Yes or No?***
Is this massage/bodywork medically necessary ***(Is it for a medical condition, injury, surgery)***? ***Yes or No?***
If yes, please explain:

Massage Information
Have you ever received professional massage/bodywork before? ***Yes ☐ No ☐***
How recently if so and how often?

What kind of pressure do you prefer? *(Please Circle)* **Light/ Medium/ Firm/Deep Tissue?**

What are your goals/expected outcomes for receiving massage/bodywork? ***Please Circle & Explain if Needed***
(Relaxation/Stress Reduction/Reduction in Pain Issues/Injury/ Other)

Do any of your symptoms interfere with your activities of daily living ***(Ex: Sleep, Exercise, Work, Childcare)***? ***Yes/ No?***
Please Explain: (If Necessary):

Do you have any allergies to scents/lotions/oils or any type of heat sensitivities? ***Yes/No Please List:***

List the medications and/or vitamins/herbal supplements you currently take:
(Certain medications can interfere/ effect sessions and/or cause one to bruise more easily such as w/ blood thinners):

Are there any areas you ***DO NOT want worked on***? ***Please Circle or List (Ex: Feet, Glutes/Hips, Scalp, Face, Chest/Pecs)***
Are you wearing contacts? Yes ☐ No ☐
Are you wearing dentures? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐ If yes, how far along?

Clinic Name *Touch of Ascension Therapeutic Massage (Page 2 of 2)*

Health History

Have you had any injuries/surgeries in the past that may influence today's treatment? **Yes/No? Please Explain If So:**

Please circle: Any of the following health conditions that you currently have (If You Are Unsure, Please Ask):

*Please Answer Honestly, as massage may **NOT** be indicated for the below conditions and could be problematic.*

(Blood clots, Infections, Congestive Heart Failure, Contagious Diseases, Breathing Problems, Pitted Edema, Cold/Flu,Bronchitis/Pneumonia, Cancer)

Please Indicate/Circle ANY CONDITIONS that you HAVE NOW or IN THE PAST that could affect today's treatment.

Explain in Detail, Including Treatment Received Now or In Past:

Current Past Muscle/Joint pain/Joint Stiffness (***Please Circle)***
Current Past Numbness And/or Tingling (***Please List Location of Body)***
Current Past Swelling (***Please List Location)***
Current Past Bruise easily
Current Past Sensitive to Touch/Pressure
Current Past High OR Low Blood Pressure (***Please Circle)***
Current Past Stroke, Heart Attack
Current Past Varicose veins ***Location on body?***
Current Past Shortness of Breath or Asthma ***(Please Circle)***
Current Past Cancer **Type?** ***Benign/Malignant***? ***Date of Diagnosis:***
Current Past Neurological (**EX: MS, Parkinson's, Epilepsy/Seizures, Fibromyalgia, CFS**)
Current Past Lupus
Current Past Headaches, Migraines
Current Past Dizziness, Ringing in the Ears
Current Past Digestive conditions (**EX: Crohn's, IBS)**
Current Past Gas, Bloating, Constipation
Current Past Kidney Disease, Infection
Current Past Arthritis (**Rheumatoid, Osteoarthritis)**
Current Past Osteoporosis, Degenerative Spine/Disk
Current Past Scoliosis
Current Past Broken Bones
Current Past Allergies ***Type of allergy(s)?***
Current Past Diabetes *Type 1 or 2?* ***Insulin Dependent? Yes/No*** ***On Insulin Pump? Yes/No***
Current Past Endocrine/Thyroid conditions
Current Past Depression, Anxiety
Current Past Memory Loss, Confusion, Easily Overwhelmed

Other Health Conditions Not Listed:

Any Other Info Needed For Therapist Before My Treatment:

Consent for Treatment:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/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.

I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly.

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 practitioner's part should I fail to do so. I also understand that any sexually suggestive remarks/advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: *Date:*

Parent or Guardian Signature (In case of a minor): *Date:*

Printed Name: