SPACIBO

THERAPEUTIC MASSAGE

# REGISTRATION & HISTORY

New Client Intake Form

## 1 CLIENT INFORMATION

**Date**

**Client Name**

**Address**

**City**

**State**

**Zip**

**Sex**

☐ M ☐ F

**Age**

**Birthdate**

**Marital status**

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

***Email**

**Occupation**

**Employer**

**How did you hear about us?**

☐ Google ☐ Yelp ☐ Instagram ☐ Friend / Referral ☐ Groupon ☐ Other: _____

**Referred by**

## 2 CONTACT & EMERGENCY

**Home Phone**

**Cell Phone**

**Best time & place to reach you**

**In case of emergency, contact**

**Relationship**

**Emergency Home Phone**

**Emergency Work Phone**

## 3 CLIENT CONDITION

**Describe your main concern or goal**

**When did your symptoms appear?**

**Duration**

☐ Acute (under 4 wks) ☐ Subacute (1–3 mo)

☐ Chronic (3+ mo)

**Current pain level** (0 = no pain, 10 = worst)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Treatment received so far**

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None

☐ Other: _____

**Type of pain**

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

**How often? Constant or comes & goes?**

**Interferes with**

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

**Painful activities / movements**

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

**Doctor(s) / healthcare practitioners who have treated you**

**Name**

**Name**

**Phone**

**Phone**

## 4 MASSAGE HISTORY & PREFERENCES

**Ever received a professional massage?**

☐ Yes ☐ No

**Did it help?**

☐ Yes ☐ No ☐ Unsure

**What results would you like to achieve?**

**Areas to prioritize**

**Areas to AVOID**

**Session preferences**

Pressure: ☐ Light ☐ Medium ☐ Firm ☐ Deep Music: ☐ Yes ☐ No Talking: ☐ Yes ☐ No

## 5 HEALTH HISTORY

***Please check any conditions or symptoms you currently have or have had in the past:***

- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Breathing Difficulty
- ☐ Bursitis
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaw Pain / TMJ
- ☐ Lymphedema
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tendonitis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors / Growths
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Whiplash

**Other**

| MEDICATIONS (and what for) | ALLERGIES | VITAMINS / HERBS / MINERALS |
|---|---|---|
| | | |
| | | |
| | | |

**Exercise**

☐ None ☐ Daily ☐ Moderate

☐ Heavy

**Sleep**

☐ Poor ☐ Fair ☐ Good

**Work activity**

☐ Sitting ☐ Standing

☐ Light Labor ☐ Heavy Labor

**Stress level**

☐ Low ☐ Moderate ☐ High

**Lifestyle**

Smoking: _____ packs/day

Alcohol: _____ drinks/wk

☐ Coffee / Caffeine

Water intake: ☐ Low ☐ Mod ☐ High

**Are you pregnant?** ☐ Yes ☐ No **Due date** _____

**Additional medical conditions, surgeries, accidents, injuries**

## 6 AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status. I hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me. I understand that massage therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. Information exchanged during massage sessions is educational in nature and is to be used at my own discretion.

### CANCELLATION POLICY

We require a minimum of 24 hours notice to cancel or reschedule an appointment. Missed appointments or cancellations made with less than 24 hours notice will be charged the FULL session fee.

**Client Signature** **Date**