



# HOPE IN HANDS

BODYWORK AND MASSAGE

## CONFIDENTIAL CLIENT INTAKE FORM

PLEASE PRINT LEGIBLY

NAME \_\_\_\_\_ EMAIL \_\_\_\_\_

OCCUPATION \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ APT / SUITE # \_\_\_\_\_

CITY / STATE / ZIP \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMERGENCY CONTACT NAME / NUMBER \_\_\_\_\_

HOW DID YOU HEAR ABOUT HOPE IN HANDS? \_\_\_\_\_

### MEDICAL INFORMATION

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? YES NO IF YES, WHEN / HOW OFTEN?

\_\_\_\_\_

ARE YOU PREGNANT? YES NO IF YES, HOW FAR ALONG?

\_\_\_\_\_

ARE YOU SENSITIVE TO TOUCH (TICKLISH) OR PRESSURE? YES NO IF YES, WHERE ON THE BODY?

\_\_\_\_\_

ARE YOU ALLERGIC OR SENSITIVE TO ANY OILS (ESSENTIAL. NUT, SCENT, ETC.)? YES NO IF YES, PLEASE LIST:

\_\_\_\_\_

LIST OF CURRENT MEDICATION(S) AND PURPOSE(S): \_\_\_\_\_

\_\_\_\_\_

LIST OF SURGERIES (BY TYPE AND DATE): \_\_\_\_\_

\_\_\_\_\_



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## TREATMENT INFORMATION

**DO YOU EXERCISE OR PLAY SPORTS? YES NO IF YES, WHICH AND HOW OFTEN?**

\_\_\_\_\_

**DO YOU PERFORM STRENUOUS OR REPETITIVE MOVEMENTS IN YOUR OCCUPATION OR SPORT? PLEASE EXPLAIN:**

\_\_\_\_\_

**PLEASE CHECK AND / OR INDICATE ALL CONDITIONS THAT APPLY:**

**SKIN:** RASH, WARTS, HIVES, OTHER:

\_\_\_\_\_

**LYMPH:** SWOLLEN GLAND, NASAL CONGESTION, EDEMA, OTHER:

\_\_\_\_\_

**JOINT:** STIFFNESS, ARTHRITIS, TMJ, SACROILIAC, OTHER:

\_\_\_\_\_

**BONE:** OSTEOPOROSIS, FRACTURE, OTHER:

\_\_\_\_\_

**HEADACHE AND / OR MIGRAINE**

**CIRCULATORY:** HIGH BLOOD PRESSURE, CLOTS, VARICOSE VEINS, OTHER:

\_\_\_\_\_

**RECENT INJURY:** WHIPLASH, SPRAIN / STRAIN, BRUISE, OTHER:

\_\_\_\_\_

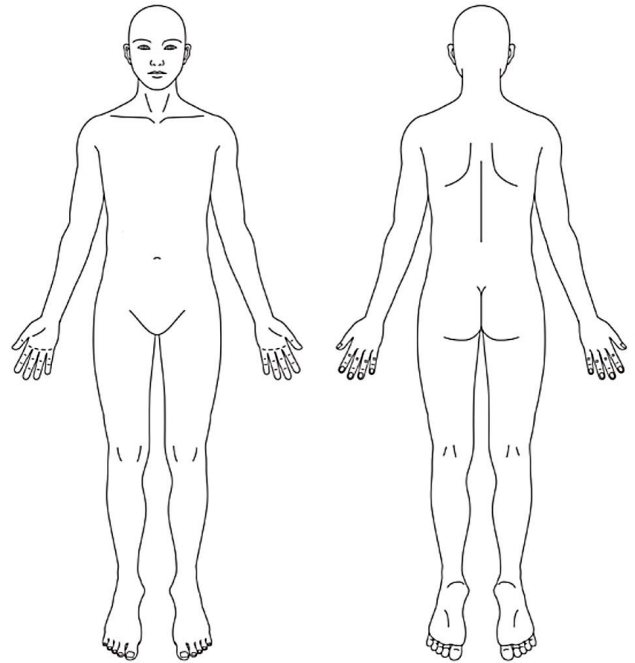
**NUMBNESS, TINGLING, OR SCIATICA**

**TENDONITIS OR BURSITIS**

**DIABETES**

**CANCER:** \_\_\_\_\_

**OTHER:** \_\_\_\_\_



**IN THE DIAGRAM ABOVE, PLEASE CIRCLE ANY AREAS WHERE YOU ARE HAVING PAIN OR DISCOMFORT.**

**SIGNATURE:** \_\_\_\_\_

**TODAY'S DATE:** \_\_\_\_\_

**By signing, you acknowledge and accept Hope In Hands' Client Policies.**