Client Intake Form

Jennifer Lickson Swan, LMT

MA57158

First Name _____

Last Name _____

Email Address _____

Home Phone # _____

Street Address _____

State _____

Emergency contact name _____

Emergency contact relationship _____

Emergency phone # _____

Date of initial visit _____

Date of birth _____

Referred by _____

Mobile Phone # _____

Work Phone # _____

City _____

Zip Code _____

Physician's name _____

Physician's phone # _____

How would you rate your general health?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Have you had a professional massage before?

- ◯ Yes *(Date of last treatment)* _____
- ◯ No

List current medications & the conditions they are treating

_____

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List any major accidents or surgeries (including dates)

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_____

Please tell us about any allergies or hypersensitivities

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_____

Reason for initial visit

_____

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_____

HEAD NECK

- ○ Headaches / migraines
- ○ Vertigo / dizziness
- ○ Ringing in ears
- ○ Hearing loss
- ○ Vision problems
- ○ Vision loss

RESPIRATORY

- ○ Asthma
- ○ Shortness of breath
- ○ Chronic cough
- ○ Bronchitis
- ○ Emphysema
- ○ Sinusitis
- ○ Frequent colds
- ○ Smoker
- ○ Family history of respiratory difficulties

NERVOUS SYSTEM

- ○ Sensory loss / change
- ○ Numbness / tingling
- ○ Sciatica
- ○ Epilepsy
- ○ Seizures
- ○ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ○ Arthritis
- ○ Family history of arthritis
- ○ Osteoporosis
- ○ Tendonitis
- ○ Bursitis
- ○ Jaw pain (TMJ)
- ○ Pins / plates / wires / artificial joint

REPRODUCTIVE

- ○ Pregnant
- ○ Given birth
- ○ Gynecological problems

CARDIOVASCULAR

- ○ High blood pressure
- ○ Low blood pressure
- ○ Heart attack
- ○ Stroke
- ○ Heart disease
- ○ Poor circulation
- ○ Phlebitis / varicose veins
- ○ Pacemaker
- ○ Hemophilia
- ○ Chronic congestive heart failure
- ○ Family history of cardiovascular problems

SKIN & INFECTIONS

- ○ Hepatitis
- ○ HIV / AIDS
- ○ Herpes
- ○ Tuberculosis
- ○ Lyme disease
- ○ Infectious skin conditions

OTHER CONDITIONS

- ○ Cancer
- ○ Diabetes
- ○ Unexplained weight loss
- ○ Digestive conditions
- ○ Fibromyalgia
- ○ Chronic fatigue syndrome
- ○ Depression
- ○ Anxiety
- ○ Psychiatric disorder
- ○ Other conditions _____

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_____

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

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