



**CONFIDENTIAL CLIENT HEALTH INTAKE FORM**

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Email Address (optional): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Have you ever received a professional massage? Y / N Type: \_\_\_\_\_

What results would you like from today's massage? \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long: \_\_\_\_\_

Hobbies regularly pursued: \_\_\_\_\_

Approximately how much time per day/week/month? \_\_\_\_\_

Stress reduction/exercise activities: \_\_\_\_\_

Approximately how much time per day/week/month? \_\_\_\_\_

Are you currently under the care of a health care practitioner? Y / N

If so, please list name and location: \_\_\_\_\_

Please list any medications, supplements or natural remedies/herbs you currently take: \_\_\_\_\_

What of the above have you taken today and when? \_\_\_\_\_

If you have had any surgeries, accidents, injuries, major illnesses or hospitalizations, please list them and the date(s) and treatment(s): \_\_\_\_\_

Are any of the above conditions still affecting you? If so, what and how? \_\_\_\_\_

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It is important that I do no harm during your massage session. Please answer the following questions honestly and completely by marking anything that applies to you. Thank you.

Do you now or have you in the past had any of the following conditions? (if so, please circle when)

Shingles	now/past	Numbness/tingling	now/past
Trigeminal Neuralgia	now/past	Sciatica/Pinched nerve	now/past
Heart condition	now/past	High/low blood pressure	now/past
Varicose veins	now/past	Blood clots	now/past
Thrombosis/embolism	now/past	Tendonitis/bursitis	now/past
Arthritis/gout	now/past	Low back/hip/leg pain	now/past
Neck/shoulder/arm pain	now/past	Jaw pain/TMJ	now/past
Osteoporosis	now/past	Asthma/ allergies	now/past
Respiratory problems	now/past	Cancer/tumors	now/past
Irritable bowel syndrome	now/past	Chronic Fatigue	now/past
Sinus problems	now/past	Pregnancy	now/past
Menstrual pain/PMS	now/past	Kidney/bladder ailment	now/past
Chronic pain	now/past	Sleep disorders	now/past
Migraines/headaches	now/past	Anxiety/depression	now/past
Inflammation/swelling	now/past	Infection	now/past
Fever	now/past	Constipation/diarrhea	now/past
Gas/bloating	now/past	Sprains/strains	now/past
Skin allergies/rashes	now/past	Athlete's foot	now/past
Herpes/cold sores	now/past	Muscle spasms/cramps	now/past

Alcohol or Drug use, including prescription drugs(within last 4 hours? Y or N)

Communicable illness (please specify)\_\_\_\_\_

Any other known conditions:\_\_\_\_\_

Are you wearing contact lenses? (Y or N)

Are you bothered by scents, oils or lotions? \_\_\_\_\_

I understand that massage or bodywork should not be construed as a substitute for medical treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment.. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe for 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 prior to any future sessions and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. The practitioner also reserves the right to refuse service to anyone for any reason.

Client Signature:\_\_\_\_\_ Date:\_\_\_\_\_