Flourish Wellness Center- Client Intake

In order to maximize the effectiveness and safety of our sessions, we ask that you take the time to fill out this confidential questionnaire.

Client Name (first and last) _____ **Date** _____

Address _____ **City**_____ **State** _____

Phone _____(cell / home / work)

Email_____ **Date of Birth** _____

Occupation_____

Are there any areas you would like your therapist to focus/ spend extra time? _____

Please check off if you are having pain/ tension/ discomfort in any of the following areas

___ upper back ___shoulders ___neck ___lower back ___glutes

___arms/ hands (left/ right) ___legs/feet (left/right) ___face/ jaw ___scalp/ head

Preferred pressure: _____Light _____Medium _____Deep _____Unsure

Please check is you **would** like the following worked on (no extra charge)

___ Face ___Scalp ___Feet ___Glutes

Habits:

How long has it been since your last massage? _____

Exercise (type and how often) _____

Posture assumed most of the day _____

Daily water intake (approximately how much) _____

Medical History- Please indicate below any significant medical problems, as such conditions can influence the type and or depth of work done in any given area. Thankyou

__ skin conditions (acne, rash, skin cancer, other)

__ lymphatic condition (swollen glands, lymphoma, lymphedema, other)

__ recent injury or accident (whiplash, sprain, deep bruise, other)

__ circulatory condition (heart disease, varicose veins, arrhythmia, arteriosclerosis, other)

__ neurological condition (sciatica, numbness/ tingling in feet/ hands/ other, stroke, epilepsy, other)

__ joint problems/ pain/ stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other)

__ allergies (seasonal, other _____)

__ bone condition (osteoporosis, previous fracture, cancer, other)

__ headaches (migraines, PMS, tension, cluster, other)

__ emotional difficulties (depression, anxiety, psychotic episodes, other)

__ stress

__ previous surgery (state type and date_____)

__ other medical conditions (_____)

__ medications (_____)

__ are you pregnant?

I understand that the massage given to me by my therapist is for the purpose of stress, muscle tension reduction, increasing circulation, or specific reasons stated above. I understand that my therapist does not diagnose illnesses or disease and does not prescribe medical treatment, pharmaceuticals or spinal manipulations. I understand that massage therapy is not a substitute for medical care from a primary caregiver. I have stated all known physical conditions and medications and will keep my therapist updated each visit..

Signature:_____ Date:_____