Client Intake Form

Client Contact Information

Client Name: _____ Date: _____

Date of Birth: _____ Gender: _____ Occupation: _____

Address: _____ City / Province: _____ Postal code: _____

Phone: _____ Email: _____

Referred by: _____ Emergency contact/Phone#: _____/_____

Massage Information

Is this massage medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Have you ever received professional massage therapy/bodywork before? Yes ☐ No ☐

What types of massage/bodywork have you received? _____

Last treatment: _____ how often? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage therapy? _____

_____

Current Health

Do you exercise regularly and/or play any sports? Yes ☐ No ☐

If yes, what kind of exercise/sports? _____

Do you perform any repetitive movements in your work, sports, or hobby? Yes ☐ No ☐

If yes, describe: _____

Do you sit for long hours at a workstation/computer or driving? Yes ☐ No ☐

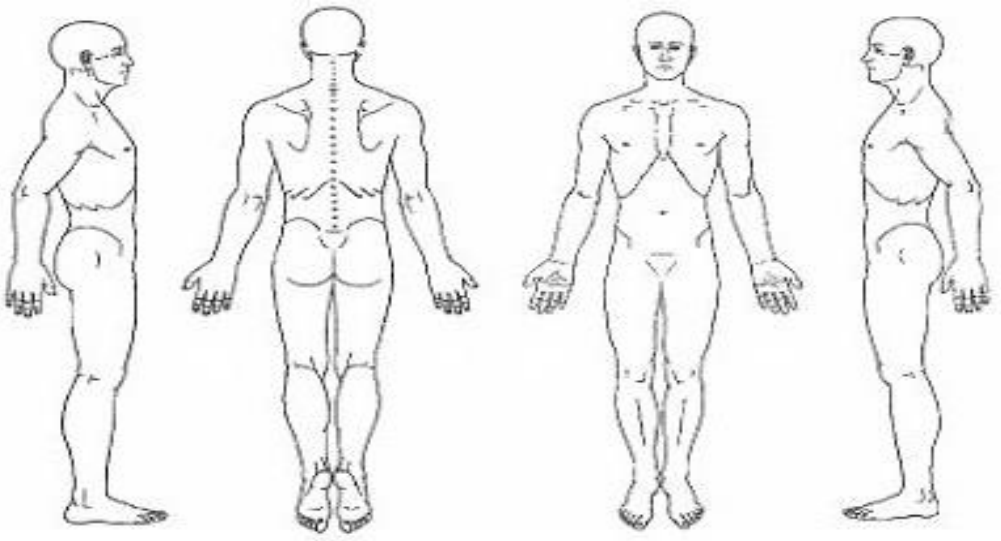
If yes, describe: _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

List the medications you currently take: _____

***Please indicate on the diagram below areas of pain and tightness with an "X" and areas that you want to be worked on with an "O".**



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Are you a smoker? Yes ☐ No ☐
Are you wearing contacts? Yes ☐ No ☐
Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐

Health History

Musculoskeletal	**Nervous System**	**Digestive**
__Bone or Joint Disease __Tendonitis/Bursitis __Arthritis/Gout __Jaw Pain __Lupus __Spinal Problems __Migraines/Headaches __Osteoporosis __Muscle or Join Pain __Scoliosis __Broken bones __Herniated Disc (Where? _____)	__Shingles __Numbness/Tingling __Pinched Nerve __Chronic Pain __Paralysis __Multiple Sclerosis __Parkinson's Disease __Epilepsy, Seizures __Sciatic Symptoms	__Irritable Bowel Syndrome __Bladder/Kidney Ailment __Colitis __Crohn's Disease __Ulcers
Respiratory	**Reproductive**	**Psychological**
__Breathing Difficulty/Asthma __Emphysema __Allergies, Specify: _____ __Sinus Problems	__Pregnant, Stage _____ __Ovarian/Menstrual Problems __Prostate	__Anxiety/Stress Syndrome __Depression __Insomnia
Circulatory	**Skin**	**Other**
__Heart Condition (Stroke, Heart Attack) __Varicose Veins __Blood Clots __High/Low Blood Pressure	__Allergies, specify: _____ __Rashes __Cosmetic Surgery __Athlete's Foot __Herpes/Cold Sores __Bruise easily __Sensitive to touch/pressure	__Cancer/Tumors __Diabetes __Drug/Alcohol/Tobacco Use __Contact Lenses __Dizziness, Ringing in ears __Hearing Aids __Thyroid conditions __Memory loss, confusion, easily overwhelmed

Any other medical condition(s) not listed: _____
_____

Please explain any of the conditions that you have marked above: _____
_____

Have you had any injuries or surgeries in the past or recently that may influence today's treatment?
_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots **/** infectious skin disease **/** congestive heart failure **/** contagious diseases **/** pitted edema **/** open wounds **/** recent surgeries **/** on blood thinners **/** high risk pregnancy **/** abdominal hernia **/** immediate after chemotherapy or radiation **/** osteoporosis

****Please answer honestly, as massage may not be indicated for the above conditions without consulting with your Doctor.**

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat 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 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. Understanding all of this, I give my consent to receive care.

Right of Refusal

STARR Clinic therapists reserve the right to refuse any treatment if a patient is deemed to be under the influence of alcohol or any recreational drugs, or if there is any inappropriate comments or behaviours. You as the Client are to be advised that you may change or refuse any or all parts of the treatment now or at anytime.

Cancellation Policy

A minimum of 24 hours notice is required if you are unable to keep your scheduled appointment. If you fail to show up for your appointment or if you cancel an appointment without sufficient notice, you agree to pay the full cost of the treatment. This Cancellation Policy applies to each appointment you make.

STARR Clinic Disclaimer

You the Client agree that you will not hold STARR Clinic responsible for any lost or stolen items, as well as any personal injuries, that occur during your scheduled treatment with our in-house therapist from STARR Clinic.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____