

Intake Questionnaire

Name _____ Sex M ___ F ___ D.O.B. _____

Address _____

City _____ State _____ Zip: _____

E-mail _____

Primary Phone: _____ Home Work Mobile

Secondary Phone: _____ Home Work Mobile

Activities of Daily Living (the type of activity involved in your life, i.e. sitting, lifting, keyboarding, driving, etc.):

Referred by or read ad in: _____

Emergency contact: Name _____ Phone: _____

Have you had a professional massage? Yes ___ No ___ Are you a regular massage client? _____

Reason for therapeutic massage (major complaint): _____

What treatment have you had for this condition? _____

Is there anything that makes your condition worse? _____

Are you currently being treated by any of the following? If yes, please signify
___ Medical Dr; ___ Chiropractor; ___ Psychiatrist. Due to HIPPA regulations any
communication with your medical provider will be conducted via the client. _____ (Please Initial)

Please list any medications presently using and their propose:

Med. _____ Purpose: _____

Med. _____ Purpose: _____

Med. _____ Purpose: _____

Med. _____ Purpose: _____

Have you had any surgery? Yes ___ No ___ Please explain: _____

Please complete information on the back of this form.

The pressure of your massage should be: Deep/Stress release _____ Moderate _____ Light/Nurturing _____

Sleeping position: Back_____ R.side_____ L.side_____ Stomach_____ No. of Pillows: 1__ 2__ 3__ 4__

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Please check any of the following conditions that apply:

- | | | | | | |
|-----------------------------------|--|---|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cramps | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hematoma | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Poor Circulation | |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Stiff Neck | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Survivor of Abuse | <input type="checkbox"/> Varicose Veins | | | |

Other Condition: _____

I understand that the massage/bodywork I receive is provided for the basics purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform Carter so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or 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 that I am aware of. 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 update Carter as to any changes in my medical profile and understand that there shall be no liability on Carter's part should I fail to do so.

Date: _____ Signature: _____