TimeSpaceOne Healing Arts

Client Intake Form

Name _____ Phone _____

Address _____ Email _____

_____ Date of Birth _____

Emergency Contact _____ Phone _____

Occupation _____ Referred by _____

Health/Medical History:

Are you seeing a health care professional?	Yes/No	Date of last checkup: _____
Are you taking any prescribed medications?	Yes/No	Type: _____
Aye you taking any supplements, herbs, over the counter meds, or known blood thinners?	Yes/No	Type: _____
		_____
Do you have any allergies?	Yes/No	Type: _____
Are you wearing any prosthetics?	Yes/No	Type: _____

Are you experiencing, or do you have the following :

____ Cold/Flu	____ Burns/Sunburn	____ Headaches
____ Fever	____ Numbness/Tingling	____ Arthritis/Tendonitis
____ Skin Conditions/Warts	____ Cuts/Bruises	____ Depression/Anxiety
____ Possible Pregnancy	____ Digestive Disorders	____ Muscular/Skeletal Disorders
____ Contagious Conditions	____ Infection	____ New tattoos/Piercings

Have you ever been diagnosed with, or been advised to seek treatment for:

____ High/Low Blood Pressure	____ Varicose Veins	____ Osteoporosis
____ Stroke/TIA's	____ Bruising Easily	____ Disc Disorders
____ Heart Disease	____ Seizure Disorders	____ Cancer
____ Aneurysm	____ Anemias/Blood Disorders	____ Phlebitis/Blood Clots

Any other conditions not mentioned above? _____

_____

_____

MT use only _____

_____

_____

_____

_____

Have you ever had any hospitalizations, surgeries, accidents, injuries, broken and/or dislocated bones?
Yes/No If yes, please explain (include dates) _____

_____

_____

_____

Massage History:

Have you received therapeutic massage before? _____ If yes, Frequency: _____

Date of last massage: _____ Likes and/or dislikes: _____

Do you prefer music, nature sounds or quiet ? _____

If yes to music or nature sounds what type? _____

Do you prefer oil or cream? _____

Do you prefer no talking, moderate talking or a lot of talking? _____

Do you prefer the room to be cooler or warmer? _____

What hobbies, activities, or recreation do you participate in? _____

Please read and sign:

Massage is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. Massage services are designed to be a health aid and in no way are meant to take the place of a physician's care. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly and I understand that is my responsibility to keep the massage therapist updated as to any changes in my medical profile.

I also understand that:

- Any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.
- Payment is due when services are rendered unless other arrangements have been made prior to my appointment.
- I will give 24 hours notice if I cannot keep an appointment. Failure to do so will result in the credit card used to hold my appointment time being charged for the service I scheduled.
- I understand that by signing this form I agree to pay for any future appointments missed or not rescheduled within 24 hours. Failure to do so will prohibit me from being seen until any balance owed is paid in full.

Signature: _____ Date: _____

Consent to Treatment of a Minor

By my signature below, I hereby authorize _____ to administer massage, reflexology, and/or bodywork therapies to my child or dependant, as they deem necessary.

Printed name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

Breast Massage Intake Form - Acknowledgement/Consent for Breast Massage

The purpose of massage to the breast is to maintain, promote, restore, and relieve congestion or discomfort in the upper chest and breast tissue by moving body fluids. Breast massage may ease tightness to scar formation from surgery, and can promote range of motion. The nipple area is never touched. You are always safely and professionally draped. The treatment will stop at your request if the massage seems uncomfortable for any reason. Your privacy is always respected.

In order to provide the best quality therapy, kindly answer the following questions:
Do you ever experience breast discomfort? Yes/No If yes, when? _____

_____

Is it cyclical? Yes/No How long does it last? _____
When were your breasts last examined by a physician? _____
When was your last physical? _____
Do you conduct monthly breast exams? Yes/No
Do you know how to examine your breasts? Yes/No
When was your last mammogram? _____
Do you massage your breasts? Yes/No
How many hours a day do you wear a bra? _____
Do you wear an underwire bra? Yes/No
Do you have marks on your skin when you remove your bra? Yes/No
Have you had any type of breast surgery? Yes/No If yes, when and what type of surgery?

_____

Do you have breast implants? Yes/No Any problems? Yes/No If yes, what type?

_____

Have you ever had one or more lymph nodes removed? Yes/No If yes, when and how many nodes were removed? _____
Do you have scar tissue on your breasts, chest or abdomen? Yes/No
Have you ever had radiation therapy? Yes/No
Would you consider breast massage? Yes/No

I, _____
(Client)

understand that the practice of massage for the breasts is performed to relieve congestion and edema in the upper chest and breast tissue, to ease tightness due to scar formation from surgery, to increase range of motion, move the lymph, prevent stagnation, alleviate breast symptoms of PMS, honor and reconnect a woman's body, enhance milk flow and production for breast feeding, ease discomforts of pregnancy and breastfeeding, reduce breast pain, ease the discomforts of pregnancy, release the diaphragm and improve respiration, and to increase the flow of blood, toxins, lymph fluid throughout the breast tissue as well as soften the fascia. I understand that the massage therapist does not prescribe or perform medical treatment nor spinal manipulation. It has been made clear to me that massage does not substitute for medical examination or treatment. It is the right of the client or therapist to stop the massage at any time for any reason.

_____ _____
(Client) (Date)

_____ _____
(Massage Therapist) (Date)

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Pregnancy Intake Form

Please check (√) current problems, mark with (+) if you had in the past :

___ anemia
___ leaking amniotic fluid *
___ bladder infection *
___ uterine bleeding *
___ blood clot or phlebitis *
___ chronic hypertension *
___ abdominal cramping *
___ diabetes (gestational or mellitus)
___ edema/swelling
___ fatigue
___ headaches
___ insomnia
___ high blood pressure *
___ leg cramps
___ miscarriage *
___ nausea
___ problems with placenta *
___ pre-term labor *
___ preeclampsia (toxemia) *
___ sciatica
___ separation of the rectus muscles
___ separation of the symphysis pubis
___ skin disorders/ athletes foot
___ twins or more! *
___ varicose veins
___ visual disturbances *
___ previous cesarean birth
___ contagious conditions
___ muscle sprain / strain
___ heart attack / stroke
___ arthritis
___ carpal tunnel syndrome
___ allergy to nut oils
___ low blood pressure
___ bursitis
___ hypo or hyperglycemia
___ contact lens
___ other conditions or problems in current or past pregnancy _____

_____

Anything else you would like me to know? _____

_____

_____

I am experiencing a low risk / high risk (circle one) pregnancy according to my doctor/midwife. If I am currently having or develop complications (any conditions/symptoms listed above with *) I will discuss the condition with my massage therapist, and will have a medical release for bodywork signed by my prenatal care provider before continuing bodywork.

I have completed this health form to the best of my knowledge. I understand that Bodywork is a health aid and does not take the place of a physician's care. Any information exchanged during a Massage or Bodywork session is confidential and is only used to provide you with the best health care services.

My due date is _____.
This is my ____ (number 1st, 2nd, etc.) pregnancy. This will be my ____ (number 1st, 2nd...) birth.
I am ____ (number) weeks pregnant in my ____ (1st, 2nd, 3rd) trimester

Name (signature) _____ Date _____