WILD WELLNESS studio

Client History And Intake Form

Name:______________________ D.O.B:____/____/____ Referred by:______________________

Address:______________________ Post Code:__________ Phone:(M)__________

Occupation:__________ Health Fund: __________ What are your concerns for today's session? __________

Emergency contact name :______________________ Phone: __________

Please state any recent or past injuries or medical treatments: ______________________

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Massage generally is very beneficial; sometimes it may not be appropriate if a certain condition is relevant. Please mark all conditions that apply now.

☐Headaches/migraines
☐Arthritis / tendinitis
☐Any type of cancer
☐Varicose veins / DVT
☐High blood pressure
☐Low blood pressure
☐Blood clots
☐Spinal disorders
☐Numbness / tingling
☐Shortness of breath
☐Fatigue

☐Diabetes
☐Asthma
☐Chest pain
☐Sleep difficulties
☐Sinus problems
☐Needle Phobia
☐Infectious diseases
☐Skin disorders
☐Broken bones
☐Circulation problems
☐Fainting spells

☐Neck pain
☐Back pain
☐shoulder pain
☐Depression
☐Herniated disc
☐Abdominal hernia
☐Digestion problems
☐Heart condition
☐Allergies
☐Pregnancy Trimester ___
☐Sprains / strains

Have you had a massage treatment before? ☐ Yes ☐ No

Do you experience difficulty lying on your ☐ Front ☐ Back ☐ Side or in a seated position?☐

Are you on any medication(s)? ☐Yes ☐No (If yes what kind) ______________________

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Are you under medical care or supervision now? ☐Yes ☐No (If yes for what)______________________

____

Medical Supervisor name: ______________________ Phone: __________

General Information Use only by massage therapist: ______________________

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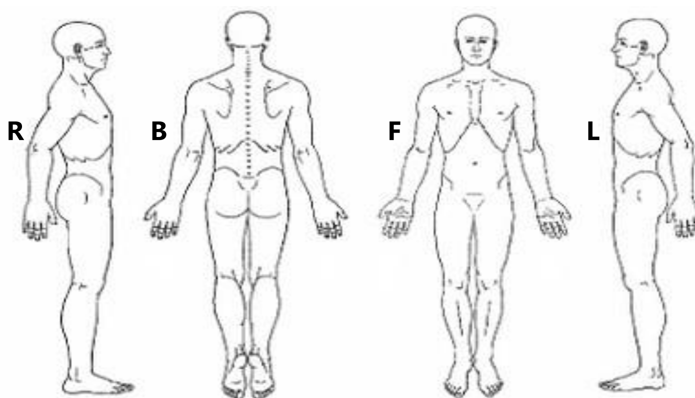
Please mark with an **x** location(s) of sore or painful areas on the diagram below and indicate the severity:

Pain scale: Minor – 1 2 3 4 5 6 7 8 9 10 – **Severe**



I (print name) ______________________ declare that all Information provided in the ***client history and intake form*** is accurate and complete. I understand that the therapist is required to know all past and present medical conditions. I will take it upon myself to keep the Massage therapist up to date on my health during any treatments.

Financial Policy: Clients to pay at the end of each visit, unless prior arrangements have been made.

Signature:______________________ Date:____/____/____