



Tim Stahlke, LMT

massage wellness relaxation

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## Intake and Health Information (page 1 of 2)

### Client Contact Information

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician/Health-care Provider name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Is this session being covered by a gift certificate? Yes  No

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

Do you have a physician referral/prescription? Yes  No

Are you seeking insurance reimbursement? Yes  No  **Insurance processing is NOT provided at this time.**

Type of insurance coverage for this claim:  Car Collision  Worker's Compensation  Private health

### Massage Information

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

How recently? \_\_\_\_\_

What types of massage/bodywork do you prefer? \_\_\_\_\_

What kind of pressure do you prefer? Light  Medium  Firm

What are your goals/expected outcomes for receiving massage/bodywork? \_\_\_\_\_

How do you feel today? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes  No

Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List the medications you currently take: \_\_\_\_\_

Do you have any special needs I should prepare for? Yes  No  Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Specify any areas you want avoided during your massage: \_\_\_\_\_

Please list any questions or concerns you have: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



- Are you wearing contacts?      Yes  No
- Are you wearing dentures?      Yes  No
- Are you wearing a hairpiece?    Yes  No
- Are you pregnant?              Yes  No
- Do you have piercings?         Yes  No

# Intake and Health Information (page 2 of 2)

## Health History

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

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Indicate any of the following health conditions that you currently have (if you are unsure, please ask):

- blood clots     i nfections     c ongestive heart failure     c ontagious diseases     p itted edema

*Please answer honestly, as massage may not be indicated for the above conditions.*

Have you received a vaccination within the last 48 hours?    Yes  No

Please indicate conditions that you have now or have had in the past. Explain in detail, including treatment received:

- Current     Past    Muscle or joint pain \_\_\_\_\_
- Current     Past    Muscle or joint stiffness \_\_\_\_\_
- Current     Past    Numbness or tingling \_\_\_\_\_
- Current     Past    Swelling \_\_\_\_\_
- Current     Past    Bruise easily \_\_\_\_\_
- Current     Past    Sensitive to touch/pressure \_\_\_\_\_
- Current     Past    High/Low blood pressure \_\_\_\_\_
- Current     Past    Stroke, heart attack \_\_\_\_\_
- Current     Past    Varicose veins \_\_\_\_\_
- Current     Past    Shortness of breath, asthma \_\_\_\_\_
- Current     Past    Cancer \_\_\_\_\_
- Current     Past    Neurological (e.g. MS, Parkinson's, chronic pain) \_\_\_\_\_
- Current     Past    Epilepsy, seizures \_\_\_\_\_
- Current     Past    Headaches, Migraines \_\_\_\_\_
- Current     Past    Dizziness, ringing in the ears \_\_\_\_\_
- Current     Past    Digestive conditions (e.g. Crohn's, IBS) \_\_\_\_\_
- Current     Past    Gas, bloating, constipation \_\_\_\_\_
- Current     Past    Kidney disease, infection \_\_\_\_\_
- Current     Past    Arthritis (rheumatoid, osteoarthritis) \_\_\_\_\_
- Current     Past    Osteoporosis, degenerative spine/disk \_\_\_\_\_
- Current     Past    Scoliosis \_\_\_\_\_
- Current     Past    Broken bones \_\_\_\_\_
- Current     Past    Allergies \_\_\_\_\_
- Current     Past    Diabetes \_\_\_\_\_
- Current     Past    Endocrine/thyroid conditions \_\_\_\_\_
- Current     Past    Depression, anxiety \_\_\_\_\_
- Current     Past    Memory Loss, confusion, easily overwhelmed \_\_\_\_\_

Comments:

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## 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.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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