BLOSSOM & BE
WELLNESS RETREAT
Therapeutic Bodywork • Spiritual Development • Women's Health

Client Intake Form
Therapeutic Bodywork

Today's Date_____

Name _____ Phone _____

Address _____City/State/Zip _____

Email _____Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

How did you find out about us?_____

The following information will help plan a safe and effective sessions. Please answer to the best of your knowledge.

Have you had a professional massage before? ☐ Yes ☐ No If yes, how often _____

Do you have any difficulty lying on your: ☐ Front ☐ Back ☐ Side

What is your dominant side? ☐ Left ☐ Right

What position do you sleep? ☐ on belly ☐ on side ☐ on back ☐ move all around

Do you have sensitive skin/ or any allergies to oils, lotions, or ointments? ☐ Yes ☐ No

If yes, please explain _____

Are you wearing? ☐ contact lenses ☐ dentures ☐ hearing aid other _____

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

If yes, please describe _____

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

If yes, please describe _____

What is your typical exercise routine?

_____

What is your typical diet?

_____

Do you experience stress in your work, family, or other aspect of your life? ☐ Yes ☐ No

If yes, how do you think it has affected your health?

☐ Muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ depression other _____

What are your stress management tools ?

_____

What areas of your body do you experience tension, stiffness, pain or other discomfort?

_____

What specific areas to you want the massage therapists to focus on?

_____

Do you have any particular goals in mind for this massage session? ☐ Yes ☐ No

If yes, please explain

_____

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Medical History

In planning a massage that is safe and effective, we need some general information about your medical history.

Are you currently under medical supervision? ☐ Yes ☐ No MD's name_____

If yes, please explain _____

Do you see a chiropractor? ☐ Yes ☐ No How often? _____ DC's name_____

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list _____

Other health team members (PT, LAc) _____

Please check any condition listed below that applies to you:

- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ accidents / injuries
- ☐ surgeries
- ☐ fractures
- ☐ artificial joints
- ☐ sprains/strains
- ☐ decreased sensations
- ☐ back/neck problems
- ☐ headaches/migraines
- ☐ depression/anxiety
- ☐ swollen glands
- ☐ current fever
- ☐ osteoporosis
- ☐ epilepsy
- ☐ diabetes
- ☐ cancer
- ☐ TMJ
- ☐ fibromyalgia
- ☐ tennis elbow
- ☐ easy bruising
- ☐ phlebitis
- ☐ heart condition
- ☐ high or low blood pressure
- ☐ insomnia/sleep disorder/apnea
- ☐ carpel tunnel syndrome
- ☐ varicose veins
- ☐ atherosclerosis
- ☐ allergies/sensitivities
- ☐ rheumatoid arthritis/osteoarthritis/tendonitis
- ☐ deep vein thrombosis/blood clots
- ☐ pregnancy - If yes, how many months? _____
- ☐ other _____

Please explain any condition marked above (include dates)

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

- **Draping will be used during the session – only the area being worked on will be uncovered.**
- **Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age 17.**

I, _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and my confidentiality may be waived. I also understand that the License Massage Therapy reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client _____ Date_____

I want Blossom & Be Wellness exercise videos, health news, and my birthday gift emailed to me: ☐ Yes ☐ No