



## **Body in Balance Massage Therapy & Hydrotherapy**

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### **New Patient/Client Intake Form**

**Personal Information - Patient information contained within this form is considered strictly confidential**

Name:

Today's date:

Email:

Address:

Phone:

DOB: (mm/dd/yy)

Gender: (M/F)

Marital Status:

#Children:

Occupation:

Emergency Contact Name:

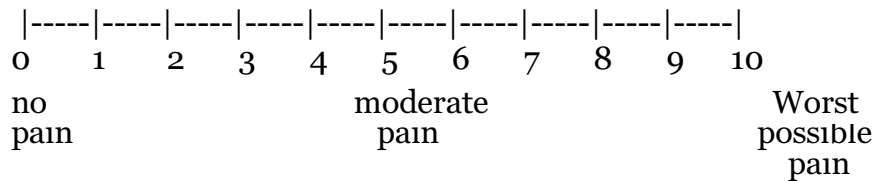
Phone:

Relation:

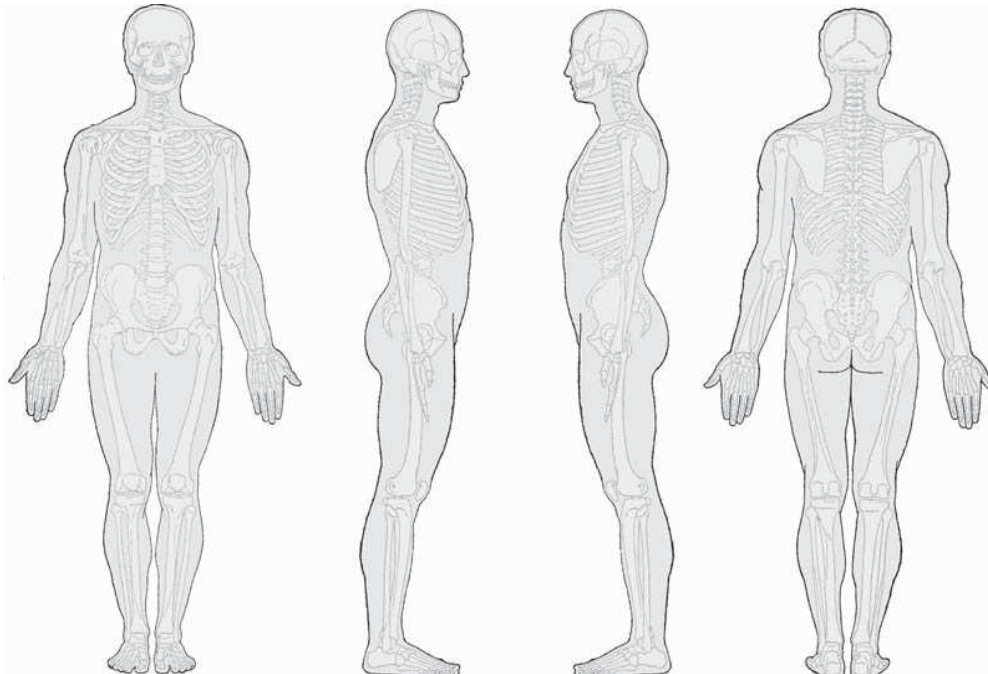
What brings you in for massage today?:

(eg., pain in right leg, sore neck, headache, just want to relax, etc.)

#### **0-10 Numeric Pain Intensity Scale**



Please **mark the area(s)** of pain/discomfort on the figures below



When did you first notice this condition?:

(eg., fell down last Friday, training for marathon/overdid it, general stress)

Have you had massage therapy previously?: (Yes/No)

If yes, when was your last massage?:

What are your treatment goals today?: (eg., reduce pain, relax, reduce stress, etc.)

Describe any physical and/or repetative activities you do on a regular basis?: (including work-related, recreational, sports etc.)

## Past Medical and Health Information

Are you currently being treated for any medical conditions?: (Yes/No) \_\_\_\_\_

If yes, what medical condition?: \_\_\_\_\_

When was the date of your last medical visit?:

(please note chiropractic and/or physical therapy visits if applicable)

Are you currently being treated for any other health condition(s): \_\_\_\_\_

(if yes, please list)

Do you know what your blood pressure is? \_\_\_\_\_

## List all prescription, medications and/or nutritional supplements you are taking

What:

(eg., lipitor, echinecia)

For:

(e.g., high blood pressure, diabetes, general health)

What:

For:

What:

For:

## Please list chronic conditions, accidents, broken bones, serious illnesses, hospitilizations

eg., Arthrtis, MS, diabetes, high blood pressure, broken arm (even accidents a long time ago can effect you today)

Condition:

Date:

Condition:

Date:

Condition:

Date:

## Your Personal Preferences During Massage Treatment

We endeavor to provide you with the skills and environment you require in order to make your massage therapy & hydrotherapy treatment fit your needs today. ***Please - don't hesitate to let us know how we can better serve you!***

Temperature: **(circle one)** Warmer: I prefer the masssage table to be **kept warm at all times**

Cool: I prefer **no heat be used at all**

May change: I prefer to **let you know throughtout the treatment** if I would like to have you change the temperature on the table

No Preference: I don't have a preference - **please proceed as you deem appropriate** and I will let you know if anything needs to be changed

Music: **(circle one)**

No music

Traditional massage therapy-type music

Soft/classic rock

Jazz

Classical

no particular preference - **you choose**

Talking/Conversation:  
**(circle one)**

**None** - please limit talking **only to what is needed** to proceed through treatment

**A little** is OK - a bit of conversation in the beginning and towards the end is fine but not too much

**Talking is fine** - my therapist may talk as much or as little as they like

**No Preference**: anything is fine with me

### Consent to Treat

I (patient/client) understand that massage therapy *may* enhance relaxation, reduce pain, increase range of motion, improve circulation and offer a positive experience of therapeutic touch.

I understand that massage therapy *may* temporarily; increase circulation, effect blood sugar and *could* cause temporary muscle soreness or tenderness.

I understand that massage therapy has contraindications - reasons that massage therapy may not be appropriate for me- or require modification to make it safe for me .

I understand and agree that I have informed my massage therapist of all my known physical conditions, medical conditions and medications. I agree to keep my massage therapist updated on any changes when I schedule subsequent treatment appointments.

I understand and agree that massage therapy is *not a substitute* for medical treatment or medications and that it is recommended that I work *concurrently* with my primary healthcare provider for any condition(s) that I may have and if appropriate inform my primary healthcare provider of my massage therapy treatments and have them provide a referral if needed.

I understand and agree that my massage therapist does not diagnosis illness, disease or prescribe medication.

Patient/Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_