Liraz Bergman-Turner, LMT, NCTMB

Client Intake Form

Name _____ Date _____

Phone # _____ / _____

Address _____

Email _____

Date Of Birth _____ Age _____ Occupation _____

Chief complaint _____

How long with this condition/stress? _____

Are you seeing someone else for the condition/stress? _____

Who? (Physician, Acupuncture, physical therapy, chiropractic, naturopathic):

_____

Health History

Check any or all that apply to your present health:

___ Headaches	___Chronic Pain	___Varicose Veins
___Muscle or Joint Pain	___Blood Clots	___ Sinus Problems
___ Back Pain/Sciatica	___Numbness/ Tingling	___High/Low Blood Pressure
___Heart Problems	___Cancer/ Tumors	___ Respiratory Problems/ Asthma
___Sprains/ Strains	___Diabetes	___ Fatigue
___Scoliosis	___Other Spinal Problems	___ Depression
___Arthritis/ Joint Disease	___Infectious Disease	___ Sleep Difficulties/ Insomnia
___Tendonitis	___Skin Diseases	___ Pregnancy
___ Allergies	___Osteoporosis	___Digestive Problems

What are your goals for the treatment? _____

Rate your stress level on a scale of 1-4 (1=Low, 4=High) _____

Are you aware of any tension holding spots in your body? _____

Have you had a professional Massage/Shiatsu/Reiki before? . . . . . Yes / No

Do you exercise regularly and/or participate in any sports? . . . . . .Yes / No

Have you recently suffered an injury/ Broken Bones? . . . . . Yes / No

Have you had any areas of inflammation recently? . . . . . Yes / No

Have you had recent surgery? . . . . . .Yes / No

Prescription drugs/ Over the counter drugs/ Herbs/ Vitamins / Supplements:

_____

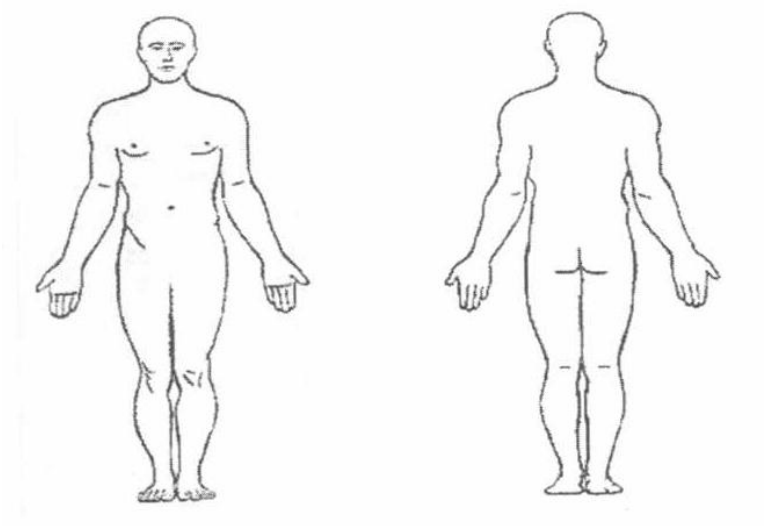
_____

Any other medical condition(s) the therapist should be aware of?

_____

_____

Please indicate where you experience pain on the drawing below:



Consent for Care

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Client Signature_____