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MINDFULNESS
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# Patient Intake Form

**CONFIDENTIALITY: Any information exchanged on this form or during a session is strictly confidential. It will be used for the sole purpose of providing the best health care services possible.**

**Patient Information:**

**Name:** _____ **Phone:** _____ **Birthdate:** _____

**Address: / City / State / Zip:** _____

**Age:** _____ ☐ **Male** ☐ **Female** **If Female, are you currently pregnant?** ☐ **Yes** ☐ **No** **If YES, what trimester are you in?** _____

**Emergency Contact:** _____ **Phone:** _____ **Relationship:** _____

**Occupation:** _____ **How did you hear about us?** _____

**CURRENT HEALTH: General and Medication Information:**

**Are you "basically in good health"?** ☐ **Yes** ☐ **No** **Has there been a change in your health in the past year?** ☐ **Yes** ☐ **No**

**IF YES, please explain:** _____

**Are you currently or have you been under a physician's care or have you had surgery within the last 6 months?** ☐ **Yes** ☐ **No**

**If yes, please explain:** _____ **Physician:** _____ **Phone:** _____

**Are you taking any prescription medications?** ☐ **Yes** ☐ **No** **If YES, please list:** _____

**Are you experiencing any tension, stiffness, discomfort or pain?** ☐ **Yes** ☐ **No** **If YES, please describe:** _____

**Have you received massage therapy before?** ☐ **Yes** ☐ **No** **If YES, what type of massage have you had (Swedish, deep tissue, shiatsu)?** _____

**What is your primary concern or goal for today's session?** _____

**Please take a moment to carefully read the following questions and answer as indicated. If you have a specific medical condition or specific symptom, massage/bodywork may be contraindicated. A referral from your primary care provider may be necessary before service can be provided.**

**MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. INCLUDE ALL AFFECTED AREAS**

| | | |
|---|---|---|
| Numbness ==== | Pins & Needles ++++ | Burning XXXX |
| Stabbing //// | Cramps ~~~~ | Dull Aching ^^^^ |

**If you answer "YES" to any of these questions, please explain on the bottom of this form.**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Do you have any allergies/sensitivities? |
| ☐ | ☐ | Do you have high or low blood pressure? |
| ☐ | ☐ | Do you suffer from arthritis or joint swelling? |
| ☐ | ☐ | Do you have swelling? _____ |
| ☐ | ☐ | Do you have diabetes? |
| ☐ | ☐ | Do you have epilepsy or seizures? |
| ☐ | ☐ | Do you have any cardiac or circulatory problems including any heart conditions or blood clots? |
| ☐ | ☐ | Do you have any difficulty breathing or have asthma? |
| ☐ | ☐ | Do you have cancer or any tumors/cysts? |
| ☐ | ☐ | Do you have any infectious or contagious diseases? |
| ☐ | ☐ | Have you been in an accident or suffered from any injuries in the past 2 years? |
| ☐ | ☐ | Do you bruise easily? |
| ☐ | ☐ | Do you have any bruises? |
| ☐ | ☐ | Is there any other medical condition I should know about? |

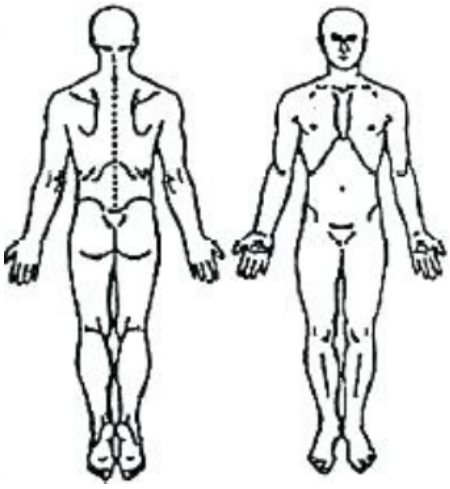
_____

**List for BACK of body:**

_____
_____
_____
_____

**List for FRONT of body:**

_____
_____
_____
_____



**BACK** **FRONT**

**CLIENT AGREEMENT:**

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 of effectiveness of individual techniques or series of appointments. I acknowledge 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. I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to adhere to any self- care plan we select and to communicate with my practitioner anytime I feel my well-being is being compromised.

_____ _____
**Client Signature** **Date of Initial Visit**