Bodywork Intake Form

TRISH FORTUNE
WELLNESS COACH
MINDBODY SPECIALIST, LMT

General Information

Client Name:_____ Date:_____

Phone #: (H)_____(C)_____Email Address: _____

Mailing Address:_____Zip Code:_____

Sex: M☐ F☐ Age:_____ Birth date: ____/____/____

Marital Status: S☐ M☐ W☐ D☐ Children: #_____ ages:_____

Occupation:_____ Company:_____

How did you hear about me?_____

Disclosure

The purpose of collecting this information is to uncover any contraindications and to determine an effective course of treatment. Please be honest in your answers. All information will be kept confidential.

Treatment Background

How often do you receive professional bodywork (ie. Massage, CranioSacral Therapy, Reiki, Thai massage or other forms of therapy)?

☐ Never, this is my first session
☐ On vacations and special occasions
☐ 5 times a year
☐ I am on a maintenance schedule of once a month
☐ I receive a massage once a week
☐ Other _____

Where do you typically go for bodywork?_____
_____

What were the results?_____
_____

Activities of Daily Living

What is your current occupation?_____

Does your occupation require extended periods of sitting? Y☐ N☐
Does your occupation require extended periods of repetitive movements? Y☐ N☐
(If yes, explain.)_____
Does your occupation require you to wear shoes with a heel (dress shoes)?
Y☐ N☐
Does your occupation cause you anxiety (mental stress)? Y☐ N☐

Physical Activity

What leisure activities do you engage in currently?_____

_____

List any sports or fitness activities that you engage in regularly:_____
_____
_____

Intention

What would you like to get from this massage or bodywork?_____
_____

What areas of assistance would you benefit from most? Rate each from 1-5 (5=most important)

Stress Relief	1☐	2☐	3☐	4☐	5☐
Pain Management	1☐	2☐	3☐	4☐	5☐
Increased Energy & Vitality	1☐	2☐	3☐	4☐	5☐
Alleviate Anxiety or Depression	1☐	2☐	3☐	4☐	5☐
Increased Flexibility	1☐	2☐	3☐	4☐	5☐
Overall Health	1☐	2☐	3☐	4☐	5☐

History

What is your major area of pain or concern?_____
_____

When did you first notice it?_____
_____

What brought it on?_____
_____

What activities aggravate it?_____
_____

Is this condition getting better or worse?_____
_____

Does it interfere with work?_____

Sleep?_____ Recreation?_____

Physical activity/exercise?_____

What have you done so far to get relief?_____
_____

Has there been a medical exam?_____

Diagnosis?_____

X rays?_____ Blood work?_____

What was the diagnosis?_____

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By whom?_____

Other areas of pain or concern?_____

Physician Information

Are you presently under a doctor's care?_____
_____

If so, for what condition (s)?_____

Name of physician:_____

Phone#:_____

List any medications you are currently taking:_____
_____
_____

Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes? Yes ☐ No ☐
(If yes, please explain).____

List any previous operations:_____

Previous broken bones:_____
_____

Previous accidents or injuries:_____
_____
_____

Are there any contraindications for bodywork? (ie. Pregnant, fever, other illness)_____

Before We Get Started

Are there any areas you would like the practitioner to avoid?_____
_____

Is there anything else not covered in the intake form that you feel would be of benefit to your therapist and your treatment today?
_____
_____
_____