Client Intake & Health History Form

PIVOT
muscle therapy llc

personal information

name _____ date of birth _____

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

email _____

occupation _____

referred by _____

emergency contact name (relationship) _____ emergency contact phone _____

massage experience

Have you had a professional massage before? ❒ Yes ❒ No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)? _____

How long have you been receiving massage therapy? _____

Frequency of massages? _____

What are your goals for treatment? _____

Using the figure to the right, circle areas of concern or discomfort.

Please describe the quality of pain you are experiencing ie.. (aching, stabbing, burning, numbness, tension, injury) _____

PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

health history

Musculoskeletal
___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory
___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory
___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify: _____
___ Sinus Problems

Nervous System
___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Reproductive
___ Pregnant, stage _____
___ Ovarian/Menstrual Problems
___ Prostate

current health

Reason for initial visit _____

Have you recently had an injury, surgery, or areas of inflammation? ❒ Y ❒ N

If yes, describe _____

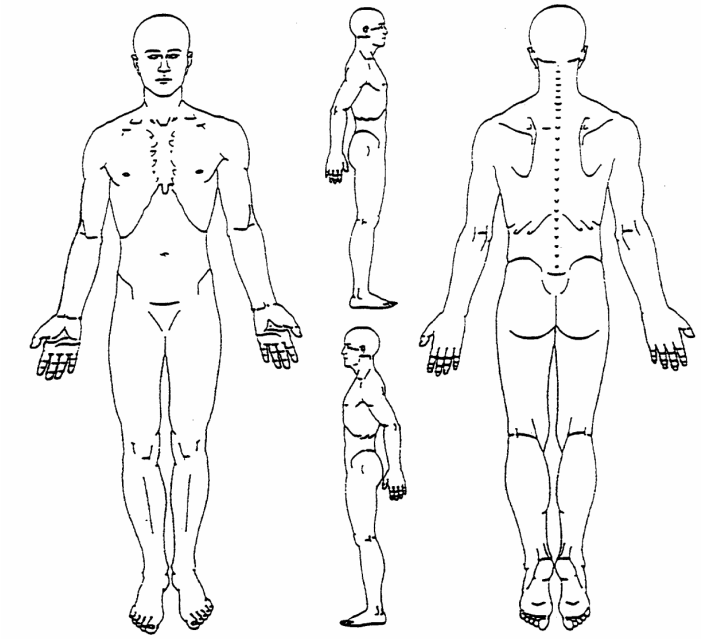
Do you have sensitive skin? ❒ Y ❒ N

Do you have any allergies to oils, lotions or ointments? ❒ Y ❒ N

If yes, please explain _____

List any medications you are currently taking _____

List any known allergies _____



Skin
___ Allergies, specify: _____
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

Digestive
___ Irritable Bowel Syndrome
___ Bladder/Kidney Ailment
___ Colitis
___ Crohn's Disease
___ Ulcers

Psychological
___ Anxiety/Stress Syndrome
___ Depression

Other
___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed: _____

Please explain any of the conditions that you have marked above : _____

* _____ client signature

_____ date of initial visit

* Indicates Consent for Massage Therapy

s.o.a.p. notes

client name

session type

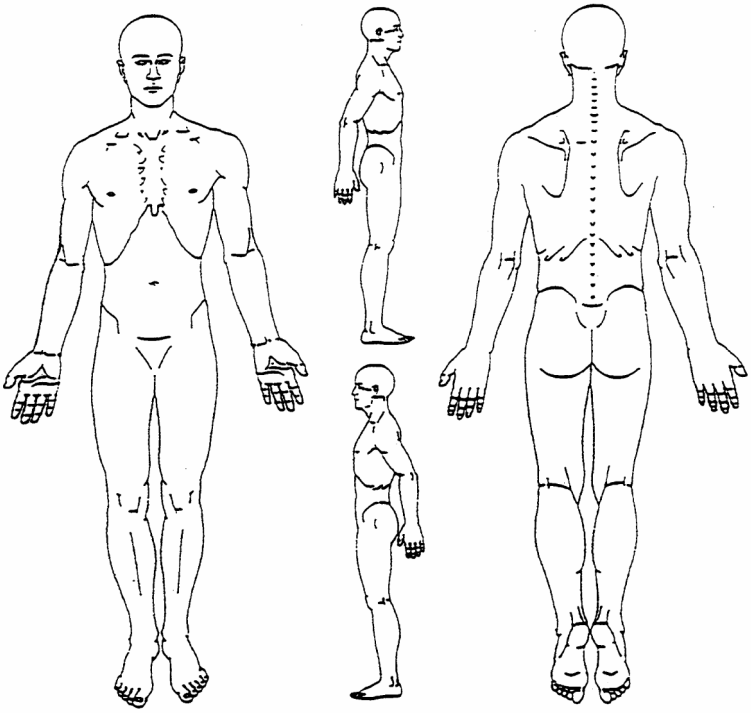
date

duration

S (Subjective) Client symptoms and information given by referring healthcare provider and by client.

symptoms:
location/intensity/duration/frequency/onset

O (Objective) Clinical observations derived from interview, palpation, visual exam and posture assessment.



A (Assessment/Application) Treatment used and client response to treatment.

P (Plan of Treatment) Treatment options, recommendations and self-care plan.

✘ Adhesion	≈ Spasm
Rotation	☼ Inflammation
○ Pain	Trigger point
• Tender Point	/ Elevation
≡ Hypertonicity	

additional notes

Therapist Signature

Date