Joshua Wooldridge L.M.T

Client Intake Form

Date:_____

Name: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: (____)_____-_____ Evening Phone: (____) _____-_____

Cell Phone: (____)_____-_____ Email Address: _____

Date of Birth: _____ Occupation: _____

Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered - Not married

Name of Spouse/ Significant other: _____

Benefits you hope to attain from this service: (Check all that apply)

☐ Reduce pain in _____
☐ Normalize body functions
☐ Lower anxiety
☐ Mind-Body-Spirit Balancing
☐ Prepare for surgery
☐ Release effects of trauma
☐ Improve circulation
☐ Improve sleep and quality of rest
☐ General healing
☐ Feel better
☐ Other: _____
_____

Preferred Appointment day and time: _____

Primary Health Care Physician: _____

Phycisian's Address: _____

City: _____ State: _____ Zip Code: _____

Phycisian's Phone: ( ) - Ext: _____

Permission to consult with Primary Physician: ☐ No ☐ Yes (*please initial if yes*)

In case of Emergency, Please notify:

Name: _____ Phone: (____) _____-_____

Relationship: _____ Alt. Phone: (____) _____-_____

15420 North 7th Street, Suite B, Phoenix, AZ 85022 ❖ (602)803-5323 Phone ❖ (602)298-6861 Fax

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Health History

Client's Name (Print Clearly)_____

List Medications on Back & Check the following conditions that apply to you.

Musculo-Skeletal
- ☐ Headaches
- ☐ Joint stiffness/ swelling
- ☐ Spasms/ cramps
- ☐ Broken/ fractured bones
- ☐ Strains/ sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, rib, abdominal pain
- ☐ Trouble walking
- ☐ Jaw pain/ TMJ
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease
- ☐ Other _____

Circulatory & Respiratory
- ☐ Blood Clots (Phlebitis or Thrombophlebitis)
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus Problems
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymph edema
- ☐ Other _____

Skin
- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other _____

Contagious? ☐ No ☐ Yes
Break in skin? ☐ No ☐ Yes

Digestive
- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/ bloating
- ☐ Diarrhea
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Other _____

Nervous System
- ☐ Numbness/ tingling
- ☐ Twitching in face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/ shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's disease
- ☐ Spinal cord injury
- ☐ Other _____

Reproductive System
- ☐ Pregnancy:
  - ☐ Current -_____ months along
  - ☐ Previous (last 6 months)
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems

Other
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Drug use - ____ times/ day
- ☐ Alcohol use -_____ drinks/ day
- ☐ Nicotine use -_____ packs/ day
- ☐ Caffeine use -_____ cups/ day
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning during urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/ Polio Syndrome
- ☐ Cancer

Anything contagious? ☐ No ☐ Yes
Explain:_____

Pain level today: _____

0→→→→→→→→→→10
No Pain — Very Painful

Explain:_____

Please use back of form to explain ALL checked conditions.

Client Initials_____

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Please explain all conditions checked on your Health History.

List of Medications:	
List ALL conditions checked on your Health History below	
Name of Condition Checked	**Explanation**

Client's Name (Print clearly)_____

Date Completed _____

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Massage Therapy Informed Consent

I, _____, (*print name*) understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any conditions I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medication and that spinal manipulations are not part of massage therapy,

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

Signature _____ Date _____

Cancellations:

Your business is valued and your cooperation is appreciated. We are making a commitment to you to guarantee your appointment time and refusing all other requests once you have made the appointment.

- ***A 24 hour cancellation notice is required for any scheduled appointment including gift certificate sessions.***
- ***Missed or no-show appointments will result in your being charged the full amount of the session booked unless the appointment can be filled.***
- ***Depending on our booking schedule, late appointments may not receive the full session time allotted for the treatment service booked. Full payment is still required.***

I have read and I agree to this cancellation policy

Print Name _____

Signature _____ Date _____

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