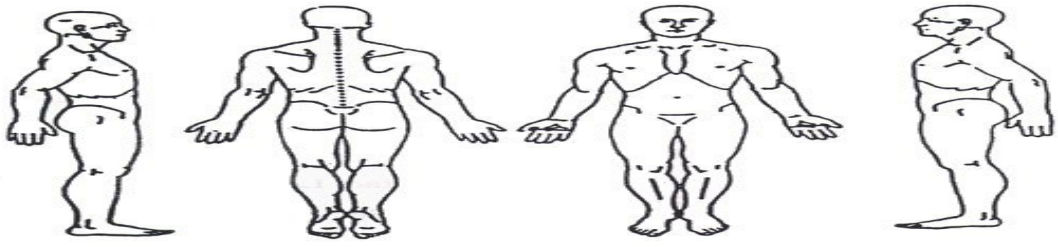
Client Intake Form - Myokinetic Massage Therapy, PLLC

Name _____ Phone _____ Cell _____
Address _____ City, State, Zip _____
Email _____ Occupation _____
Date of Birth _____ Referred By _____
Emergency Contact Name _____ Phone _____

The following information will be used to help plan a safe and effective treatment plan.
Please answer all questions to the best of your knowledge.

- Have you had a **professional massage** before? Yes No How often? _____
- Are you right handed or left handed? _____
- Favorite **sleep positions** are your back, side, stomach or a mix? _____
- Do you have **difficulties** laying on your back, side or stomach? Yes or No
- Do you have **allergies or sensitivity** to oils, lotions, ointments, fruits or nuts? Yes or No
  If yes, please explain _____
- Are you wearing: ○ contact lenses ○ dentures ○ hearing aid ○ prosthetics?
- Do you **sit or stand** for long hours at a workstation or driving? Yes or No
  If yes, please explain _____
- Do you perform any **repetitive movement** in your work, sports or hobbies? Yes or No
  If yes, please describe:_____
- How do you feel that **stress** from your work, family or other aspect of your life has affected your health?
  In the form of: ○ muscle tension ○ anxiety ○ insomnia ○ irritability ○ other _____
- Is there a **specific area** of the body where you are experiencing tension, stiffness, pain or discomfort?
  If yes, please explain_____
- When did your **symptoms first appear**…. Years? Months? Weeks? Days? _____
- Is this condition getting **progressively worse**? ○ Yes ○ No ○ Unknown
- Rate the **severity** of your pain on a scale of 1 (least pain) to 10 (severe pain)_____
- **Type of pain**: ○ Sharp ○ Dull ○ Burning ○ Cramps ○ Numb ○ Stiff ○ Swelling ○Other_____
- Is it constant or does it come and go?_____
- Does it interfere with: ○ Work ○Sleep ○ Daily Routine ○ Workout ○ Other _____
- **Activities or movements** that are painful or difficult to perform:
  ○ Sitting ○ Standing ○ Walking ○ Bending ○ Lying Down ○ Rotation ○ Flexion ○ Extension

Mark any specific areas that you experience pain:



RIGHT L - BACK - R R - FRONT - L LEFT

What treatments have you already received for your condition? ◯ Medications ◯ Surgery
◯ Physical Therapy ◯ Chiropractic ◯ Acupuncture ◯ None ◯ Other_____

Are you interested in ◯ Swedish Massage ◯ Deep Tissue Massage ◯ Myofascial Release
◯ Hot Stones ◯ Cupping ◯ Gua Sha ◯ Structural Integration ◯ Visceral Manipulation
◯ I'm not sure ***Please note that Cupping and Gua Sha will temporarily leave marking or bruising***

What are your goals for this therapy session?_____

Please mark to indicate if you have or had any of the following :

◯ AIDS/HIV	◯ Tennis Elbow	◯ Arthritis	◯ Diastasis
◯ Hepatitis	◯ Golfers Elbow	◯ Bronchitis	◯ Pregnancy
◯ Frozen Shoulder	◯ Stroke	◯ High Cholesterol	◯ Carpal Tunnel
◯ Trauma	◯ Fractures	◯ Kidney Disease	◯ Lupus
◯ Blood Clots	◯ Recent Surgeries	◯ Liver Disease	◯ Chrons
◯ Osteoporosis	◯ Joint Replacement	◯ Pacemaker	◯ TMJ
◯ Epilepsy	◯ Low Blood Pressure	◯ Pinched Nerve	◯ Digestion Issues
◯ Headaches	◯ High Blood Pressure	◯ Herniated Disc	◯ Skin Disorders
◯ Migraines	◯ Heart Condition	◯ Psychiatric Care	◯ Fibromyalgia
◯ Cancer	◯ Varicose Veins	◯ Rheumatoid Arthritis	◯ Hernias
◯ Diabetes	◯ Easy Bruising	◯ Tumors	◯ Strains/Sprains
◯ Decreased Sensation	◯ Atherosclerosis	◯ COVID-19	◯ Insomnia
◯ Back Problems	◯ Neck Problems	◯ Open Sores	◯ Multiple Sclerosis

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that I can stay as dressed or undressed as I feel comfortable during therapy. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician or other qualified medical specialist for mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all the questions honestly. I agree to keep the therapist updated to any changes in my medical profile and understand that there shall be no liability on the therapist's part if I should fail to do so.

I would like to be on the mailing list at Myokinetic Massage Therapy, PLLC for updates and promotions via
◯Email ◯ Text Messages ◯ Phone Calls ◯ Postal Mail ◯ Not Interested

Signature of client _____ Date _____

Signature of Licensed Massage Therapist _____ Date _____

Updated 8.22.22