

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 _____

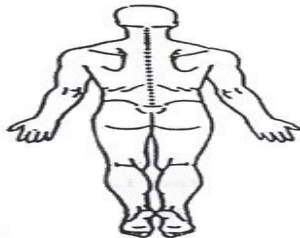
***The following information will be used to help plan a safe and effective treatment plan.
 Please answer all questions to the best of your knowledge.***

- 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 difficulty lying 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 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

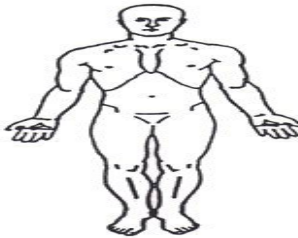
Mark any specific areas that you experience pain:



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 :

- | | | | |
|---|---|--|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Tennis Elbow | <input type="radio"/> Arthritis | <input type="radio"/> Diastasis |
| <input type="radio"/> Hepatitis | <input type="radio"/> Golfers Elbow | <input type="radio"/> Bronchitis | <input type="radio"/> Pregnancy |
| <input type="radio"/> Frozen Shoulder | <input type="radio"/> Stroke | <input type="radio"/> High Cholesterol | <input type="radio"/> Carpal Tunnel |
| <input type="radio"/> Bleeding Disorders | <input type="radio"/> Fractures | <input type="radio"/> Kidney Disease | <input type="radio"/> Lupus |
| <input type="radio"/> Blood Clots | <input type="radio"/> Recent Surgeries | <input type="radio"/> Liver Disease | <input type="radio"/> Chrons |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Joint Replacement | <input type="radio"/> Pacemaker | <input type="radio"/> TMJ |
| <input type="radio"/> Epilepsy | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Pinched Nerve | <input type="radio"/> Digestion Issues |
| <input type="radio"/> Headaches | <input type="radio"/> High Blood Pressure | <input type="radio"/> Herniated Disc | <input type="radio"/> Skin Disorders |
| <input type="radio"/> Migraines | <input type="radio"/> Heart Condition | <input type="radio"/> Psychiatric Care | <input type="radio"/> Fibromyalgia |
| <input type="radio"/> Cancer | <input type="radio"/> Varicose Veins | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Hernias |
| <input type="radio"/> Diabetes | <input type="radio"/> Easy Bruising | <input type="radio"/> Tumors | <input type="radio"/> Strains/Sprains |
| <input type="radio"/> Decreased Sensation | <input type="radio"/> Atherosclerosis | <input type="radio"/> COVID-19 | <input type="radio"/> Insomnia |
| <input type="radio"/> Back Problems | <input type="radio"/> Neck Problems | <input type="radio"/> Open Sores | <input type="radio"/> 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 Not Interested Other _____

Signature of client _____ Date _____

Signature of Licensed Massage Therapist _____ Date _____