Heals on Wheels Mobile Massage Therapy

By: Katie Adjutant, LMT

Client Intake Form

Today's Date ____/____/____

Name	Phone		
Street Address	City	State	Zip Code
Occupation	Birthdate	Height	Weight
Referred By			
Emergency Contact	Phone		
Primary Health Care Provider	Phone		

IF UNDER THE AGE OF 18, PARENT'S/GUARDIAN NAME IS REQUIRED BELOW!
The consent to treatment of minors on back of form must be signed by parent/guardian!

Mother's Name	Phone
Father's Name	Phone
Guardian's Name	Phone

IF PREGNANT

Please complete below

How many weeks/months?	Are you high risk?
Did you conceive via Fertility Assistance?	Do you have your Doctor's clearance?

GENERAL ENTRANCE HISTORY

Please complete all responses to the best of your knowledge. All information is confidential

Have you had massages, bodywork/treatments before? Y / N

If yes, when was your last massage: _____

Do you wear contact lenses? Y / N

Do you wear dentures? Y / N

Are you currently under a physicians care? Y / N

Are you taking any blood clotting medication? Y / N

Are you taking any blood thinning medication? Y / N

Are you taking any sensation-altering medication? Y / N

Do you have a tendency to bruise easily? Y / N

Have you recently been exposed to a communicable disease? Y / N

If so, please explain: _____

Do you have recent injuries? Y / N

If so, please explain: _____

Have you had any recent surgeries? Y / N

If so, please explain: _____

Have you traveled abroad in the past year? Y / N

If so, where: _____

MEDICATIONS

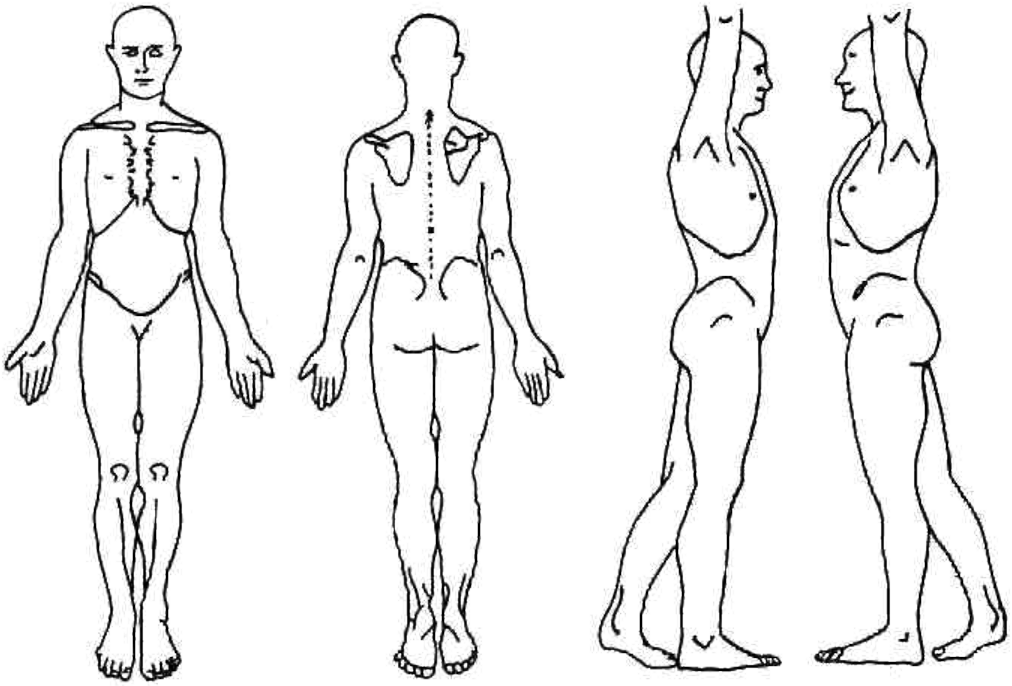
Please list any medications you are currently taking, including any patches

Medication	Dose	Condition

VITAMINS OR NATURAL SUPPLEMENTS

Please list any vitamins or supplements you are currently taking

Vitamin/Supplement	Dose	Condition



PERSONAL MEDICAL HISTORY

Please check if you have experienced any of the following in the last three months

SIGNIFICANT ILLNESSES

☐Cancer	☐Seizures	☐Thyroid Disease	☐Stroke
☐Hepatitis	☐Heart Disease	☐Venereal Disease	☐Mental Illness
☐HIV (AIDS)	☐Tuberculosis	☐Addictive Disorders	☐Migraines
☐Allergies	☐Herpes	☐High Blood Pressure	☐Concussion
☐Asthma	☐Diabetes	☐Rheumatic Fever	☐Pacemaker

GENERAL

☐Fever	☐Weakness	☐Peculiar Taste/Smell	☐Hearing Loss
☐Tremors	☐Insomnia	☐Fatigue	☐Night Sweats
☐Headaches	☐Poor Balance	☐Bleeding	☐Depression
☐Weight Change	☐Chills	☐Joint Pain	☐Bruising

MUSCULO-SKELETAL

☐Scoliosis	☐Muscle Weakness	☐Shoulder Pain	☐Leg Pain
☐Recent Sprains	☐Spasms	☐Arm/Wrist Pain	☐Foot/Ankle Pain
☐Arthritis	☐Cramps	☐Back Pain	☐Weak Joints
☐Neck Pain	☐Hip Pain		

SKIN & HAIR

☐Rashes	☐Itching	☐Dandruff	☐Psoriasis
☐Eczema	☐Hair Loss	☐Ulcers	☐Athletes Foot
☐Recent Moles	☐Hives	☐Acne	☐Dermatitis

CARDIOVASCULAR/CIRCULATORY

☐Lymphedema	☐High B.P.	☐Chest Pain	☐Palpitations
☐Blood Clots	☐Low B.P.	☐Irregular Heartbeat	☐Varicose Veins

RESPIRATORY

☐Emphysema	☐Pain Breathing	☐Persistent Cough
☐Short of Breath	☐Wheeze	☐Bronchitis

GASTROINTESTINAL/URINARY

☐Diarrhea	☐Blood in Stool	☐Nausea/Vomiting	☐Blood in Urine
☐Constipation	☐I.B.S.	☐Severe Gas	☐Kidney Stones
☐Parasites	☐Ulcers	☐Painful Urination	

Please read and sign:
I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes.

Signature: _____Date:_____

INFORMED CONSENT

I, _____, (Client) understand that massage provided by Heals on Wheels Mobile Massage Therapy by Katie Adjutant 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 Care Physician for any condition I may have. I am aware that Heals on Wheels does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not a part of massage therapy.

I have informed Heals on Wheels Mobile Massage Therapy of all my known physical conditions, medical conditions and medications, and I will keep Heals on Wheels updated on any changes. I will the massage therapist of any experience of pain during the session. I understand that no inappropriate comments or conduct will be tolerated and that any indication of such will automatically end the session. I further agree to hold harmless Heals on Wheels and all if the massage therapists against any and all claims. I further understand that massage will be administered at the discretion of the massage therapist and any medical condition contraindicated to massage will disqualify me from participating in the massage practice.

I understand and agree to all Heals on Wheels policies.

Client Signature: _____Date:_____

CONSENT TO TREATMENT OF MINORS

(Please use this portion for consent to provide massage therapy to those less than 18 years old)

I, _____ (Parent/Guardian) hereby consent Heals on Wheels to administer massage therapy techniques to _____. (massage recipient) my child of dependent as deemed necessary. Parent/guardian understands that there can be a remote risk associated with this work; parent/guardian further agrees to hold harmless Heals on Wheels and its massage therapists where the massage is being conducted against any and all claims.

Parent/Guardian Signature: _____Date:_____

CONSENT TO TREATMENT OF A PREGNANT WOMAN

(Please use this portion for consent to provide massage therapy to those who are pregnant)

I, _____ (pregnant woman client) hereby consent Heals on Wheels to administer massage therapy techniques to me and my unborn child as deemed necessary. I understand that there can be a remote risk associated with this work; I further agree to hold harmless Heals on Wheels and its massage therapists where the massage is being conducted against any and all claims for illness or injury received during the session to either myself or my unborn child.

Client Signature:_____Date:_____