Hands of Silk Massage

Client Intake Form

Date: _____

Name: _____ **Sex:** ☐ **Male** ☐ **Female**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Daytime Phone #: _____ **Evening Phone #:** _____

Cell Phone # _____ **Email Address:** _____

Date of Birth: _____ **Occupation:** _____

Employer:
_____

Marital status: ☐ **Single** ☐ **Married** ☐ **Partnered, not married**

Children's Names and Ages: _____

Name of Spouse/Significant Other: _____

Benefits you hope to attain from this service? _____
Check all that apply:

- ☐ Reduce pain
- ☐ Normalize body functions
- ☐ Lower Anxiety
- ☐ Mind-Body-Spirit Balancing
- ☐ Prepare for surgery
- ☐ Release effects of trauma
- ☐ Improve circulation of fluids & elimination
- ☐ Improve sleep and quality of rest
- ☐ General Healing
- ☐ Feel Better!
- ☐ Address specific concerns: _____

Preferred Appointment Day and Time: _____

Primary Health Care Provider: _____

Provider's Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone #: _____ **Extension:** _____

Permission to Consult with Primary Provider? ☐ **No** ☐ **Yes** _____ **(please initial if yes)**

In Case of Emergency, Please Notify:

Name: _____ **Telephone #:** _____

Relationship: _____ **Cell phone #:** _____

Health History

Medications:_____

Check the following conditions that apply to you, past and present.

Please use back of form to explain all checked conditions. **Client Initials**_____

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, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain/TMJ
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease
- ☐ Other: _____

Circulatory and Respiratory
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ 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
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Adaptive aids
- ☐ Other:_____

Nervous System
- ☐ Numbness/tingling
- ☐ Twitching of 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
- ☐ Previous
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems

Other
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Drug use _____
- ☐ Alcohol use _____
- ☐ Nicotine use _____
- ☐ Caffeine use _____
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning upon urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer

Anything contagious? ☐ **No** ☐ **Yes**

Explain: _____

Pregnant? ☐ **No** ☐ **Yes**

Nursing? ☐ **No** ☐ **Yes**

Pain level today: _____

0→→→→ →→→→→→→→10

No Pain Very painful

Explain: _____