Happy Heart Massage LLC

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Client Intake Form

Personal Information

Name_____ Phone_____

Address_____ City/State/Zip_____DOB_____

Occupation_____Email_____

Primary Physician/Midwife_____

Emergency Contact_____ Relationship_____

Phone_____

How did you hear about Happy Heart Massage?_____

Please mark any current problems and note if you've had them in the past as well:
ANY HIGH RISK conditions **require a Medical Release from your primary Dr. BEFORE** massage/body work can take place.

___anemia
___bladder infection
___uterine bleeding
___blood clot or phlebitis*
___sciatic pain/pressure
___edema/swelling
___diabetes*
___skin disorders
___heart attack/stroke*
___fatigue
___varicose veins
___headaches/migraines
___Autoimmune Disorders
___muscle sprain/strain
___anxiety/depression
___high blood pressure
___miscarriage
___nausea
___pre-eclampsia (toxemia)
___low blood pressure
___numbness
___separation of the symphysis pubis
___arthritis
___carpal tunnel syndrome
___neuropathy
___pre-term labor
___chronic pain
___arthritis
___digestive issues
___allergies
___hemorrhoids
___cancer*
___thyroid disorder
___diastasis rectus
___cesarean birth
___contagious conditions*
___twins or more!
___strains/sprains
___insomnia
___orthopedic injuries
___vaginal ring or patch as birth control method*

Please list any other medical conditions _____

_____

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

Briefly explain any history of menstruation, fertility or miscarriage issues: _____

_____

_____

Have you had a professional therapeutic massage before? _____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? _____

_____

What are your treatment goals for this session? _____

_____

Do you have an exercise routine that you practice regularly? _____

_____

Do you perform any repetitive movement in your day to day, work, sports or hobby? If yes please describe.

_____

Do you have effective ways of managing stress in your life? If so please describe.

_____

_____

Please list any injuries/accidents/illnesses still affecting you: _____

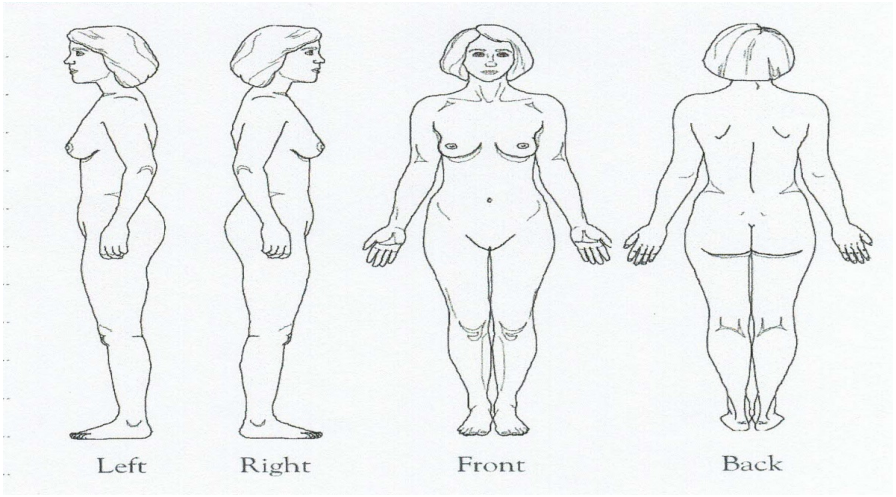
_____

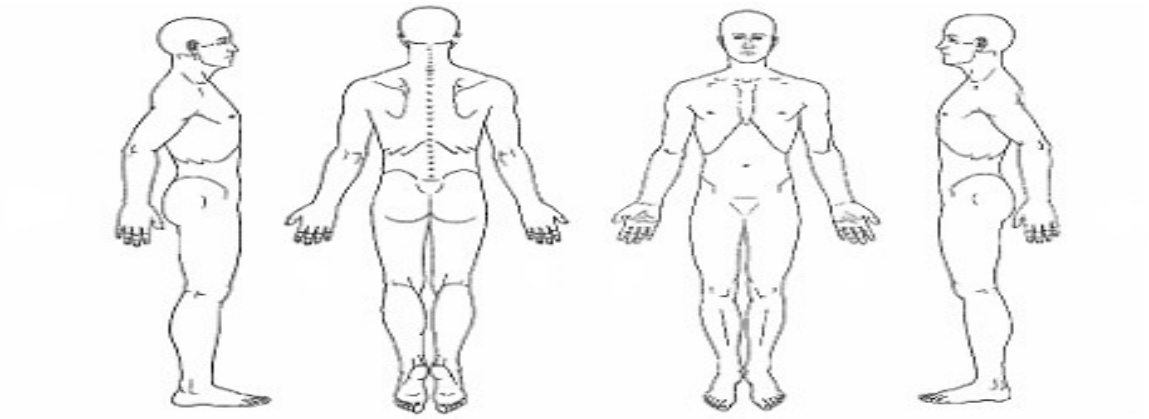
Please list any medications, supplements or birth control you are currently taking and explain:

_____

_____

Please circle any areas of discomfort





I have completed this health form to the best of my knowledge. I understand that massage is a health aid and does not take the place of a physician's care. I understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment. Any information exchanged during the session is confidential and is only used to provide you with the best health care services. I understand that taking oral contraceptives increases the risk of blood clotting and I accept the risks involved. I understand that if I have ANY condition that is considered HIGH RISK, **I must obtain a Medical Release from my primary Dr.** BEFORE I receive massage/body work.

I am currently managing _____(HIGH RISK CONDITION) and have obtained a Medical Release from my primary Dr. to receive massage/bodywork.

Signature of Client:_____

Date:_____