

Joe R. Campbell BS, LMT, LMTI, CEP

CONFIDENTIAL CLIENT HISTORY/INTAKE FORM

Last Name _____ First Name _____ MI _____

Birthdate ___/___/___ Check M F Address _____

City _____ State _____ Zip _____ E-mail _____

Home Phone (____)____/____ Bus. Phone (____)____/____ Cell Fax Pager (____)____/____

Status Single Married Employed Full-Time Student Part-Time Student Other

Referred By _____ Family Dr. _____ Dr. Phone (____)____/____

Emergency Contact _____ Phone Number (____)____/____

(initial) Sometimes, doing work on the body can bring out memories long forgotten or cause emotions to surface unexpectedly. If that happens, let me know and I'll stop and we'll decide what to do.

(initial) The responsibility for the cost for each massage therapy session is the client's. Whatever portion of the session(s) not covered by a third-party payer is the client's responsibility.

Primary reason for getting massage: Pain Relief Sports performance or recovery Relaxation

Location of pain: _____ For how long? _____

Description of pain (check all that apply) Throbbing Pins & Needles Numbness Sharp Aching
Dull Burning Constant Intermittent Occasional Other _____

What makes the condition better/worse? _____

Have you seen a physician for this condition? If yes, what diagnosis? _____

Please check all that apply to you:

- HIV Positive Contagious or infectious condition Cancer Any condition being medically supervised
- Contacts Varicose veins High/low blood pressure Dizziness Stroke Allergies to oils or fragrances
- Cardio-vascular conditions Prone to bruising Circulatory problems Pregnancy Heart Attack Diabetes

Surgeries in the last 5 years _____

List current medications _____

By signing below, I verify that I am in good physical condition and the information documented is accurate and complete. I have no physical restrictions, conditions or disabilities which would prevent me from receiving bodywork therapy. I hereby give my consent to have the bodywork therapy performed on me.

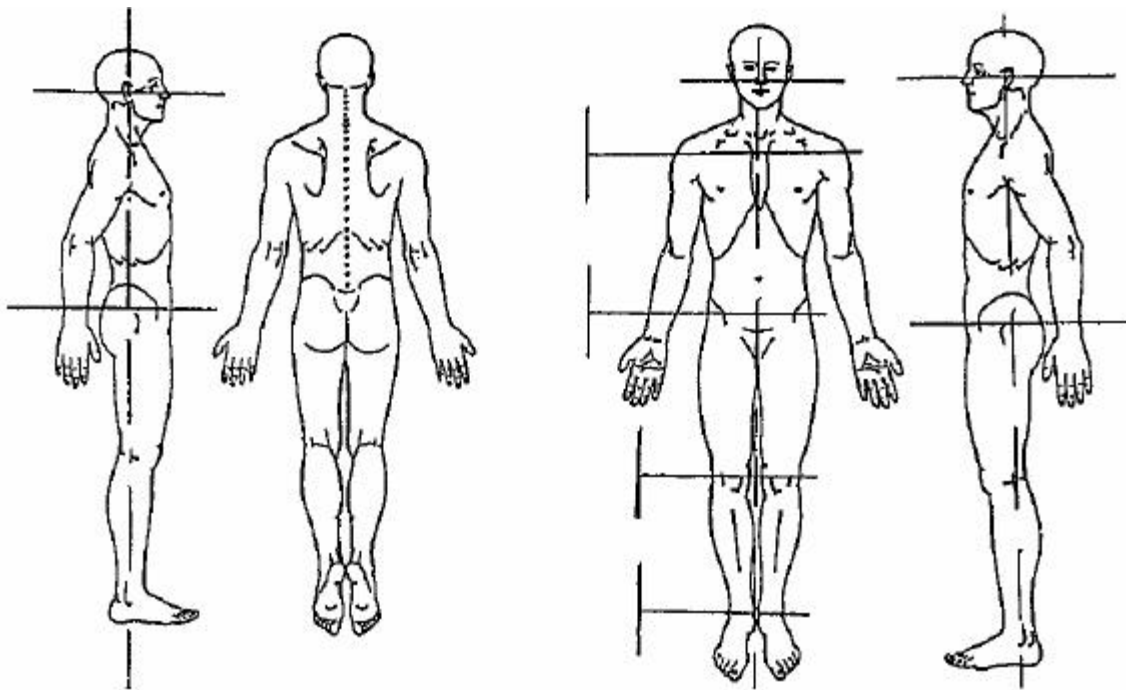
Client Signature _____ Date ___/___/___



GIVING BALANCE TO YOUR LIFE

WWW.GIVINGBALANCETOYOURLIFE.COM

Please mark on the chart below with # of surgeries, scars, bruises, or wounds. Also, place an "X" anywhere there is pain and an "O" in areas that are tight or need extra work.



GIVING BALANCE TO YOUR LIFE

WWW.GIVINGBALANCETOYOURLIFE.COM