Joe R. Campbell BS, LMT, LMTI, CEP

CONFIDENTIAL CLIENT HISTORY/INTAKE FORM

Last Name_____First Name_____MI_____

Birthday ___/___/_____ 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____/____/_____

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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.