Essential Balance
Holistic Wellness Center

Client Intake Form – Therapeutic Massage/Reiki/SET™

Personal Information:

Name _____ Phone (Cell) _____

Address _____

City/State/Zip _____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

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

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain _____

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes, please explain _____

12. Do you see a chiropractor? Yes No If yes, how often? _____

13. Are you currently taking any medication? Yes No
    If yes, please list _____

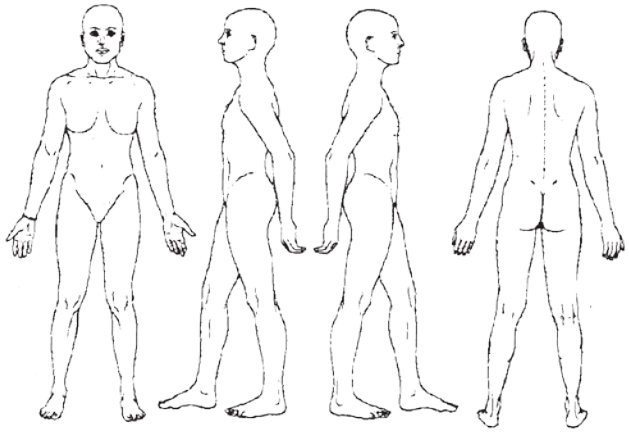
14. Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) recent accident or injury	( ) osteoporosis
( ) recent fracture	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer
( ) sprains/strains	( ) diabetes
( ) current fever	( ) decreased sensation
( ) swollen glands	( ) back/neck problems
( ) allergies/sensitivity	( ) Fibromyalgia
( ) heart condition	( ) TMJ
( ) high or low blood pressure	( ) carpal tunnel syndrome
( ) circulatory disorder	( ) tennis elbow
( ) varicose veins	( ) pregnancy If yes, how many months?
( ) atherosclerosis	

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

16. Circle any specific areas you would like the massage therapist to concentrate on during the session:



Signature of client _____ Date _____

Massage Therapist/MA _____ Date _____