StillPoint
Myofascial Release
Corrective & Therapeutic Artistry

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CLIENT INTAKE FORM

Please answer the following questions as accurately as possible.
The information provided will be helpful in creating treatment sessions that meet your specific needs.

PERSONAL INFORMATION:

Name: ______________________________ Date: ______________

Address: ______________________________ Date of Birth: ______________

____

Telephone – Home: ______________ Cell: ______________ Work: ______________

E-Mail Address: ______________________________ Occupation: ______________

Who referred you for treatment? ______________________________

MEDICAL INFORMATION:

Primary Physician or Chiropractor: ______________________________

What is the PRIMARY complaint that brings you in for treatment today? ______________________________

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Any secondary complaints you would like to address? ______________________________

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Please describe any pain, limited range of motion or difficulty with activities due to your symptoms: ______________

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How and when did these issues begin? ______________________________

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Please list history of trauma (physical or emotional), accidents or surgery: ______________________________

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What are your goals for therapy? ______________________________

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Please check any of the conditions you've had in the past or currently have:

________	Cardiovascular Disease	________	Neurological Condition	________	Sinus Problems
________	Arthritis (Osteo/ Rheum)	________	Depression	________	Anxiety
________	Asthma/ Difficulty Breathing	________	High Blood Pressure	________	Constipation/ Diarrhea
________	Vertigo/ Dizziness	________	Varicose Veins	________	Digestive Problems
________	Thyroid Condition	________	Diabetes (Type 1 or 2)	________	Pregnancy
________	Osteoporosis	________	Multiple Sclerosis	________	Numbness/ Tingling
________	HIV/AIDS	________	Fibromyalgia	________	Tendonitis
________	Chronic Infections	________	Epilepsy/ Seizures	________	Sprains/ Strains
________	Kidney Disease	________	Chronic Fatigue Syndrome	________	Muscle/ Joint Pain
________	Congestive Heart Failure	________	Headaches/ Migraines	________	Blood Clots
________	Tension/ Stress	________	Back or Neck Pain	________	Rash/ Skin Conditions
________	Sleep Disorders	________	Chest Pain/ Tightness	________	Eyestrain/ Irritation
________	TMJ/Jaw Pain	________	Earaches/ Ringing in Ears	________	Menstrual Issues

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/ HEALTH STATUS SHOULD CHANGE, I WILL INFORM MY THERAPIST IMMEDIATELY.

I understand myofascial release/ bodywork may be contraindicated. A referral from my primary care physician may be required. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that is beyond the scope of practice of my massage therapist. I understand that massage/ bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because myofascial release/ massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and have answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so. It is also my understanding that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment. I understand I will be charged for appointments I cancel or miss without 24 hours notice of my scheduled appointment. I also understand that if I arrive late I will receive the remainder of the time scheduled, but will be liable for payment in full.

Client Signature ____ **Date** ________________

Signature of Parent or Guardian to treat a minor ____

PLEASE INDICATE AREAS OF PAIN, TENSION AND/OR DYSFUNCTION.

Draw or highlight to show where you feel pain or tension, have limited range of motion, or areas that create dysfunctional symptoms.