Client Intake Form – Wendy Everett, South Bay Birth Services

Myofascial Release Therapy, Massage Therapy, L&D Preparation, Induction Massage

Name _____ Phone _____
Address _____
Email _____ Date of birth _____
Emergency Contact _____ Phone _____

The following information will be used to help your therapist provide a safe and effective session. Please answer these questions to the best of your knowledge:

Have you had other bodywork before? Yes No
Massage Chiropractic Acupuncture Cranial Sacral Reiki Other

Do you have any difficulty lying on your front, back or side? Yes No
If yes, please explain _____

Do you have any allergies to oils, lotions, or nuts? Yes No
If yes, please explain _____

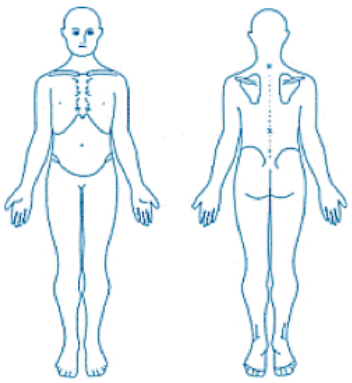
Are you wearing contacts, a hearing aid, dentures, or prosthetics? If yes, please circle.

Do you sit for long hours at a computer/workstation, watching tv, or driving? Yes No

Do you perform repetitive movement in your work, sports or hobby? Yes No
If yes, please explain _____

How do you notice stress affects your health?
Muscle tension Anxiety Irritability Insomnia Illness Other

Do you have particular goals in mind for this session? Yes No
If yes, please explain _____



Please identify and comment on any specific area of the body where you are experiencing tension, stiffness, pain or discomfort or where you would like me to concentrate.

_____
_____
_____
_____

Medical History

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

Do you currently or have you ever had any of the following?

- ❑ contagious skin conditions or open sore
- ❑ current fever
- ❑ current sprain/strain
- ❑ swollen glands
- ❑ surgery
- ❑ major accident
- ❑ broken bones
- ❑ high or low blood pressure
- ❑ diabetes or gestational diabetes
- ❑ deep vein thrombosis/blood clots
- ❑ varicose veins
- ❑ easy bruising
- ❑ migraine or chronic daily headache
- ❑ back or neck problems
- ❑ reflux
- ❑ tmj (jaw) tension/disorder
- ❑ carpal tunnel syndrome
- ❑ tendonitis
- ❑ rheumatoid arthritis/osteoarthritis
- ❑ osteoporosis
- ❑ cancer
- ❑ atherosclerosis
- ❑ joint disorder or artificial joint
- ❑ circulatory disorder
- ❑ phlebitis
- ❑ fibromyalgia
- ❑ epilepsy
- ❑ neuralgia or decreased sensation
- ❑ incontinence (urine leaking)
- ❑ constipation/bowel issues
- ❑ "morning sickness"
- ❑ pregnant – how many weeks? _____

Are you currently taking any medication (other than prenatal supplements?) Yes No

If yes, please explain _____

Are you currently under medical supervision for a condition other than pregnancy? Yes No

If yes, please explain _____

I, _____ (print name) understand the myofascial and/or massage therapies I receive are provided for the basic purpose of relaxation, release of muscular tension and release of connective tissue restrictions. L&D preparatory massage, stimulating acupressure points that encourage labor, is performed only after 38 weeks gestation. _____ (initial for acupressure.) If I experience any pain or discomfort during this session, I will immediately inform the therapist, so that appropriate adjustments can be made. I further understand that massage should not be construed as a substitute for medical examination or diagnosis and that I should see a physician, chiropractor, or other medical specialist for any medical concerns. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or medical illness and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____