

**The Viroqua Healing Arts Center
Client Intake Form**

Date: _____

Name: _____

Address: _____

Phone Number: home _____ work _____

Date of Birth: _____ Occupation: _____

Referred by: _____

In Case of Emergency Please Notify: _____ Phone: _____

Primary health care provider (physician, therapist, chiropractor, etc.):

What is the major complaint or condition you would like to improve?

What brought it on? _____

What activities aggravate the condition? _____

Does this condition interfere with: Work? _____ Sleep? _____ Daily Routine? _____

Please explain: _____

What have you done to get relief? _____

Has there been a medical diagnosis? _____

Please list (date and description) any accidents, injuries or surgeries: _____

Are you currently receiving medical /therapeutic treatment? _____ Please explain:

List any supplements or medications you are currently taking: _____

Describe any exercise and stress reducing activities you practice (include frequency):

Have you had massage or bodywork before? _____

Check the conditions that apply to you:

Pregnancy _____ Diabetes _____ Arthritis _____ Heart Disease _____ High Blood Pressure _____

Blood thinning medication _____ Varicose Veins _____ Cancer _____ Post cancer _____

Spinal or back problems _____ Headaches _____ Osteoporosis _____ Epilepsy or seizures _____

PMS _____ Hip or knee replacements _____ Immune system disorders _____ Fibromyalgia _____

Contagious diseases _____ Circulatory problems _____ Joint swelling _____ Other _____

What do you hope to gain from the massage/bodywork that you are here to receive? _____

I realize that the massage session being given here is for well-being of body and mind. This includes stress reduction, relief from muscular tension, spasm or pain or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease or any other physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: _____ DATE: _____