



***Client Intake Form***

*All information will be kept Private and confidential*

Date:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

St. Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about BodyLogic?

What is your previous experience with professional massage and body work?

What are your goals for this treatment?

Are you under medical treatment now?

If yes, what condition:

Please list your care providers name and phone number:

List any medications (including aspirin) and nutritional supplements you are currently taking:

Specify any known allergies:

How much water do you consume a day:

Nutrition (check one)  Excellent  Good  Fair  Poor

Exercise (check one)  Excellent  Good  Fair  Poor

Frequency

Are you pregnant?  Yes  No

What Trimester

### Health History

Check the following conditions that apply to you, present or past. Please add any comments for clarity.

- |  |   |
|--|---|
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Swollen Ankles           |
| <input type="checkbox"/> Migraines                   | <input type="checkbox"/> Varicose Veins           |
| <input type="checkbox"/> Joint Stiffness/Swelling    | <input type="checkbox"/> Blood Clots              |
| <input type="checkbox"/> Spasms, Cramps              | <input type="checkbox"/> Heart Condition          |
| <input type="checkbox"/> Scoliosis                   | <input type="checkbox"/> Allergies                |
| <input type="checkbox"/> Shoulder/neck/arm/hand pain | <input type="checkbox"/> Sinus Problems           |
| <input type="checkbox"/> Back or Hip Pain            | <input type="checkbox"/> High/Low Blood Pressure  |
| <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Athletes Foot            |
| <input type="checkbox"/> Jaw Pain/TMJ                | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Colitis                     | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Multiple Sclerosis          | <input type="checkbox"/> Epilepsy                 |
| <input type="checkbox"/> Muscular Dystrophy          | <input type="checkbox"/> Depression/Anxiety       |
| <input type="checkbox"/> Eating Disorder             | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Fibromyalgia                | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Infectious Disease          | Where   |
| Please List  | When  |
| <input type="checkbox"/> Insomnia                    |   |

Please list any additional comments regarding your health and well being that you feel are pertinent to your therapy

I agree that the above information is true and accurate to the best of my knowledge. I will inform my therapist of any changes in my status.

Signature: \_\_\_\_\_ Date: