Client Intake Form – AcuBalance Wellness Center

Personal Information

Name _____ email _____

Phone (Cell) _____ Phone (Home) _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

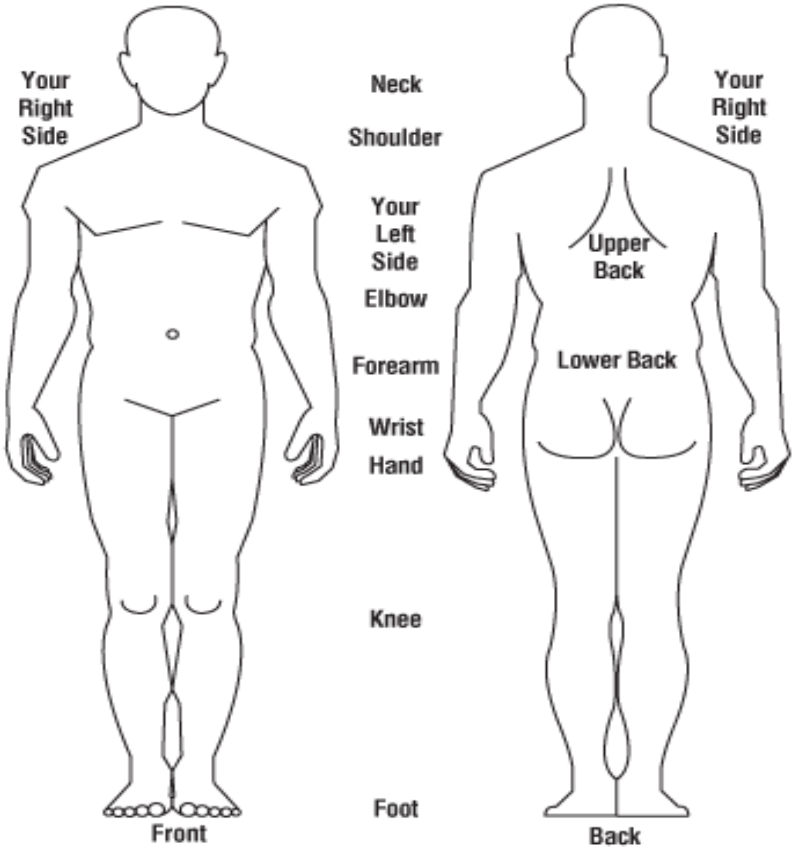
Referred by?_____ Relationship_____

The following information will be used to help plan safe and effective massage sessions.

Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Description of Chief Complaint _____
   _____
   _____
2. How long have you had this condition? _____
3. Have you had this issue in the past? Yes ☐ No ☐
   If yes, when? _____
4. Complaint is the result of: Auto Accident __ Injury__ Job Related___ Other__
5. Date of accident, injury_____
6. Have you seen any other medical professional about this condition Yes ☐ No ☐
7. If yes, when?_____
8. What makes the pain better? (circle) cold heat rest movement other
9. What makes the pain worse? (circle) cold heat rest movement other
10. Are you wearing contact lenses ☐ dentures ☐ a hearing aid ☐?
11. Do you sit for long hours at a workstation, computer, or driving? Yes ☐ No ☐
    If yes, please describe _____
12. Do you perform any repetitive movement in your work, sports, or hobby? Yes ☐ No ☐
    If yes, please describe _____
13. 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 _____
14. Do you have any particular goals in mind for this massage session? Yes ☐ No ☐
    If yes, please explain _____



Using the appropriate letters, note any areas of pain on the diagram:
D=DULL S=SHARP N=NUMBNESS T=TINGLING B=BURNING R=RADIATING A=ACHE X=OTHER

Medical History

15. Are you currently under medical supervision? Yes ☐ No ☐
    If yes, please explain _____
16. Are you currently taking any medication? Yes ☐ No ☐
    If yes, please list _____
17. 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
☐ osteoporosis	☐ epilepsy
☐ artificial joint	☐ headaches/migraines
☐ sprains/strains	☐ cancer
☐ current fever	☐ diabetes
☐ swollen glands	☐ decreased sensation
☐ allergies/sensitivity	☐ heart condition
☐ high or low blood pressure	☐ TMJ
☐ circulatory disorder	☐ varicose veins
☐ atherosclerosis	☐ pregnancy (if so, how many months?) _____

Please explain any condition that you have marked above _____
_____