# CLIENT INTAKE FORM

Joanne LMT MUIR

Today's Date

Date of Initial Visit

Referred by

Please complete & submit the following form before your session.

First Name

Last Name

Date of Birth

Phone

Email

Home Address

Physician's Name

Physician's Phone Number

Emergency Contact Name

Emergency Contact Relationship

Emergency Contact Phone

# Additional Details

How would you rate your general health?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Have you had a professional massage before?

- ◯ Yes
- ◯ No

If yes, date of last treatment

List current medications & the conditions they are treating

List any major accidents or surgeries (including dates)

Any allergies or hypersensitivies?

Reason for initial visit

Joanne Muir LMT | MA0026244
www.joannemuir.com | joannemuir@joannemuir.com

# Conditions

## HEAD/NECK

- ◯ Headaches/Migraines
- ◯ Ringing in Ears
- ◯ Vertigo/Dizziness
- ◯ Vision Loss

## RESPIRATORY

- ◯ Asthma
- ◯ Shortness of Breath
- ◯ Chronic Cough
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Sinusitis
- ◯ Frequent Colds
- ◯ Smoker
- ◯ Family History of Respiratory Difficulties

## NERVOUS SYSTEM

- ◯ Sensory Loss/Change
- ◯ Numbness/Tingling
- ◯ Sciatica
- ◯ Epilepsy
- ◯ Seizures
- ◯ Multiple Sclerosis

## OTHER CONDITIONS

- ◯ Cancer
- ◯ Diabetes
- ◯ Unexplained Weightloss
- ◯ Digestive Conditions
- ◯ Fibromyalgia
- ◯ Chronic Fatigue Syndrome
- ◯ Depression
- ◯ Anxiety
- ◯ Psychiatric Disorder

## CARDIOVASCULAR

- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Heart Attack
- ◯ Stroke
- ◯ Heart Disease
- ◯ Poor Circulation
- ◯ Phlebitis/Varicose Veins
- ◯ Pacemaker
- ◯ Hemophilia
- ◯ Chronic Congestive Heart Failure
- ◯ Family History of Cardiovascular Problems

## SKIN & INFECTIONS

- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ Herpes
- ◯ Tuberculosis
- ◯ Lyme Disease
- ◯ Infectious Skin Conditions

## MUSCULOSKELETAL SYSTEM

- ◯ Arthritis
- ◯ Family History of Arthritis
- ◯ Osteoporosis
- ◯ Tendonitis
- ◯ Bursitis
- ◯ Jaw Pain (TMJ)
- ◯ Pins/Plates/Wires/Artificial Joint

## REPRODUCTIVE

- ◯ Pregnant
- ◯ Given Birth
- ◯ Gynecological Problems

Other Conditions Not Listed

☐ *It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of the success or effectiveness of individual techniques or series of appointments.*

*I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.*

*I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.*

*Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.*

Your Signature _____