

BONNETTE NEUROMUSCULAR THERAPY AND BODYWORK

CLIENT INTAKE FORM

1 CLIENT INFORMATION Date _____ Client Name _____ _____ Address _____ City _____ State _____ Zip _____ E-mail _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____ <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years	2 PHONE NUMBERS Cell (____) _____ Home (____) _____ Best time and place to reach you _____ IN CASE OF EMERGENCY, CONTACT Name _____ Relationship _____ Cell (____) _____ Work (____) _____ Whom may we thank for referring you? _____ _____ Or how did you hear about us? _____ _____
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3 CLIENT CONDITION Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other What are your problem areas and when did symptoms appear? _____ What treatment have you already received for your condition? <input type="checkbox"/> Medication <input type="checkbox"/> Surgery <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Chiropractic Care <input type="checkbox"/> None <input type="checkbox"/> Other Type of pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other How often do you have this pain? _____ Is it constant or does it come and go? _____ Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation Activities or movements that are painful to perform: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down

4 MASSAGE HISTORY The LMT shall drape the breasts of all female clients and not engage in breast massage of female clients unless the client gives written consent before each session involving breast massage. Draping of the genital area and gluteal cleavage will be used at all times during the session for all clients. The LMT must immediately end the massage session if a client initiates any verbal or physical contact that is sexual in nature. If the client is uncomfortable for any reason, the client may ask the LMT to end the massage, and the LMT will end the session. The LMT also has a right to end the session if uncomfortable for any reason. All areas excepting the genitals may be massaged. Please note any areas the client does not want massaged and contraindications. (Circle applicable areas) Face / Breast / Buttocks / Feet / Other _____ Client Consent (must sign) for Breast Work / Pectoralis Release <input checked="" type="checkbox"/> _____
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HEALTH HISTORY

Please check conditions or symptoms you currently have or have had in the past:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Depression | <input type="checkbox"/> Infection | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> ACL | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures/Breaks | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Headaches/Migraine | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tear (Muscle, Ligament, Tendon) |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> TMJ/Jaw Pain |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> PMS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated/Bulging Disc | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cold | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Hysterectomy/C-Section | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other |

VITAMINS/HERBS/MINERALS

ALLERGIES

MEDICATIONS

EXERCISE

- None Daily
- Moderate Heavy

OCCUPATION

- _____
- Sitting Light Labor Low Stress
- Standing Heavy Labor High Stress

LIFESTYLE

- Smoking-Packs/Day _____ Caffeine-Cups/Day _____
- Alcohol-Drinks/Week _____ Recreational Drug Use

Are you pregnant? Yes No Trimester 1st 2nd 3rd Due Date _____

Bonnette NMT and Bodywork does not offer massage in the 1st trimester of pregnancy.

Client _____ Date _____ Therapist _____ Date _____

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AUTHORIZATION

The massage technique(s) used will be:

- Swedish Deep Tissue Prenatal Sports Hot Stone Neuromuscular Therapy Couples Trigger Point

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my massage therapist if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion. I am aware that if I have any serious medical diagnosis, I must provide a physician's written consent prior to services.

Please print name of Client, Parent or Guardian

Signature of Client, Parent or Guardian

Date

Please print name of Massage Therapist

Signature of Massage Therapist

Date