

CONFIDENTIAL CLIENT INTAKE FORM - INITIAL VISIT

Date: _____

How did you hear about us? Print/Ad E-mail Website Referral Friend
 Other _____

CONTACT INFORMATION

Name _____
Address _____ Apt # _____
City _____ State _____ Zip _____
Primary Phone _____ Alternate Phone _____
E-mail _____
Sex Male Female
DOB _____
Occupation _____
Referred by _____

Emergency Contact: _____
Phone _____ Relationship _____

SYMPTOMS

Primary complaint today _____

What do you think caused this condition _____

How long have you have it _____

What makes it better _____ what makes it worse _____

Does it interfere with work sleep recreation other

Have you seen a doctor Y N Diagnosis _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY

open cuts, bruises, burns skin rash/irritation sunburn inflammation
 poison ivy severe pain headache cold/flu

Michelle N. Johnson, LMT, CIMI
President/Lead Therapist
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773.732.3163

Educating. Enlightening. Empowering



HEALTH INFORMATION & HISTORY

Have you ever received therapeutic massage and/or bodywork services before? ___ yes ___ no

Type of massage/bodywork ___ Swedish ___ Deep Tissue ___ Energy work ___ Other

Was there anything you particularly liked or disliked about a previous session? _____

What are your expectations for today's session? (relieve pain, reduce stress, relaxation)

Are there any areas you DO NOT wish to have treated today?

___ stomach ___ glutes ___ face ___ other _____

Have you consumed any alcoholic beverages in the last 24 hours ___ yes ___ no

(If female) Are you pregnant ___ yes ___ no

Are you currently under physicians care ___ yes ___ no

Please explain _____

Are you currently taking medication ___ yes ___ no

Please explain _____

Are there any medications that you take on a daily basis _____
(please include all vitamins/minerals/herbs/supplements)

Is there any exercise, hobby, or sport in which you participate in regularly?

Please explain _____

Do you wear ___ contact lenses ___ prosthesis ___ hearing aid

Describe daily stress level ___ severe ___ high ___ normal ___ low

Describe daily work activity ___ sitting ___ standing ___ light labor ___ heavy labor

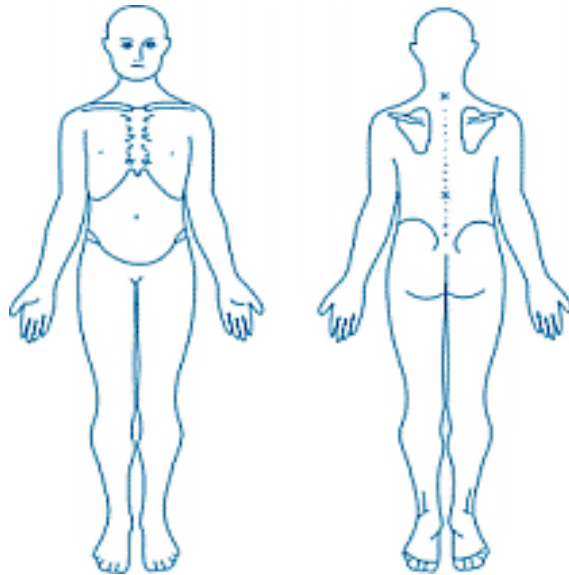
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How often do you consume the following:

Water	<input type="checkbox"/> never	<input type="checkbox"/> seldom	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Alcohol	<input type="checkbox"/> never	<input type="checkbox"/> seldom	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Salt	<input type="checkbox"/> never	<input type="checkbox"/> seldom	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Sugar	<input type="checkbox"/> never	<input type="checkbox"/> seldom	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Caffeine	<input type="checkbox"/> never	<input type="checkbox"/> seldom	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Tobacco	<input type="checkbox"/> never	<input type="checkbox"/> seldom	<input type="checkbox"/> occasionally	<input type="checkbox"/> often

ON THE DIAGRAM PRESENTED, PLEASE MARK AREAS OF DISCOMFORT WITH AN 'X', AND PAINFUL/TENDER AREAS WITH AN 'O'



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Essential-E Therapeutic Massage & Bodywork

HAVE YOU HAD, CURRENTLY HAVE, OR SUSPECT YOU MAY HAVE THE FOLLOWING

Muscular-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Carpal Tunnel Syndrome
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Sciatica
- Other: _____

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Allergies _____
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: _____

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: _____

Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Stroke
- Other: _____

Reproductive System

- Pregnancy:
 - Current
 - Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems
- Mastectomy

Other

- Loss of appetite
 - Forgetfulness
 - Confusion
 - Depression
 - Difficulty concentrating
 - Drug use _____
 - HIV/AIDS _____
 - Fainting _____
 - Hepatitis
 - Burning upon urination
 - Bladder infection
 - Eating disorder
 - Diabetes
 - Fibromyalgia
 - Sinusitis
 - Cancer
 - Infectious disease (please list) _____
 - Other congenital or acquired disabilities (please list) _____
 - Surgeries/hospitalizations _____
 - Other: _____
- For clients who need mobility assistance, please give your height: _____ weight: _____

INFORMED CONSENT AND THERAPIST RELEASE WAIVER
PLEASE READ AND SIGN BELOW

I, _____ (client) understand that any therapeutic massage and/or bodywork provided by Michelle N. Johnson, LMT (therapist) is solely intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch. The overall benefits of massage, along with possible risks, in addition to my specific treatment plan have been explained to me. Being aware of these, I exercise my choice, and give my consent for massage; understanding that there is no implied or stated guarantee of success or effectiveness for the massage session.

I understand that the massage therapist does **NOT** diagnose illness or disease, or any other physical or mental disorder(s). The therapist does **NOT** prescribe medical treatment or pharmaceuticals, nor does the therapist perform spinal manipulations as part of the massage. Massage therapy is **NOT** intended to take the place of a physician’s care, examinations or diagnosis. It is recommended that I work **WITH** a physician for any condition that I may have.

In order to provide the best possible and most effective treatment, I understand that my therapist must be aware of all known physical and medical conditions, medications and limitations, and agree to keep the therapist fully informed of any changes. As such, I understand that there shall be no liability on the therapist’s part should any problem occur due to my forgetting to disclose any pertinent information. If I experience any level of pain and/or discomfort at any time during the session, I will immediately communicate with the therapist so that treatment may be adjusted.

I understand that the therapist has the right to refuse service to anyone and will **NOT** provide massage to anyone under the influence of drugs or alcohol. I also understand that it is my right as a client to terminate the session at any time if I am uncomfortable for any reason.

I agree to call ahead if I will be late to my appointment, understanding that I will receive only the amount of time remaining in my scheduled time slot. I agree to give 24 hours notice of cancellation or I will pay the \$25.00 no call/no show fee.

I have been informed of all applicable policies and procedures and agree to abide by them accordingly.

Client Signature

Today’s Date

LMT

Michelle N. Johnson, LMT, CIMI
President/Lead Therapist
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**MICHELLE N. JOHNSON, LMT
FINANCIAL & OFFICE POLICIES
PLEASE READ CAREFULLY & SIGN**

- We require **24-HOUR NOTICE** for any schedule changes. You may call between 9:00am and 6:00pm Monday through Friday to reschedule your appointment. You are responsible for remembering when your appointments are. Clients who cancel or miss an appointment without 24 hours notice will be charged for the time reserved or a **\$50 no call/no show fee** per missed appointment unless there is a medical emergency. If you arrive late, you will receive the time remaining for your appointment but be charged for the full time reserved. If you arrive more than 15 minutes late, your appointment may be forfeited and you will be billed for the time reserved. This fee is your responsibility and is due at your next visit.
- Unless other arrangements are made, **PAYMENT IS DUE AT THE TIME SERVICE**. Fee schedules and prices are subject to change. At the time of printing, the current rates are as follows:
 - \$75 per one hour session (60 minutes),
 - \$45 per one half hour session (30 minutes - when available)
 - \$95 per one hour and a half (90 minutes – when available)

Payment Agreement and Financial Responsibility (please initial)

___ I agree to keep my account balance current by paying for services rendered in the form of currency, check, credit/debit at each visit

___ I accept full responsibility for all costs of services rendered and all fees associated with last minute cancellation and no shows.

Signature _____

Date _____

CONFIDENTIALITY AGREEMENT

Thank you for choosing me to be your therapist today. I am delighted that you have allowed me the opportunity to assist you in addressing your therapeutic massage needs. If there is anything I can do to make your experience today more enjoyable, please do not hesitate to communicate with me at anytime before, during, or after your session.

The information provided in these documents will be held in the strictest of confidence between you and your therapist. I agree that I will not disclose any information contained in this form to any outside parties without the expressed written consent of the client.

Therapist Name Michelle N. Johnson, LMT Date _____

Signature _____

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