MIND BODY BABY

PATIENT INTAKE FORM

Date:_____

Personal Information

Date of Birth: / /

First Name: _____ Last Name: _____

Address: _____

Ph: _____ Mobile: _____

□ First-time client □ Returning client

Occupation: _____ Health Fund: _____

How did you hear about us: _____

Referred by: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

HEALTH HISTORY

Precautions

SURGERY / ILLNESS / MEDICATION / ALLERGIES / PREGNANT / CAN LIE PRONE / OTHER

_____

_____

Blood pressure: Low Normal High Unsure

Have you had or do you currently have any of the following conditions? Write "P" for past conditions.

□ Chest pain □ Headaches □ Poor Circulation □ Fracture □ Thrombosis/Clots

□ Epilepsy □ Arthritis □ Recent infections □ Diabetes □ Osteoporosis

□ Endometriosis □ Cancer □ Liver Disease □ Glandular Fever □ Rheumatic Fever

□ Stroke □ Hepatitis □ HIV/AIDS □ Bone infections □ Asthma/Bronchitis

□ Skin condition □ Breathing difficulties □ Deep Vein Thrombosis □ Pregnant? # of weeks? ____

Has anyone in your **family** suffered from any of the following conditions?

□ Heart Disease □ Diabetes □ High Blood Pressure □ High Cholesterol □ Obesity

□ Stroke □ Cancer □ Neurological Disorder □ Arthritis

Sports / Hobbies: _____

Describe your typical diet (e.g. some organic, no processed foods, low caffeine):

_____

How many hours do you sleep each night? _____

Do you have restful sleep? Y / N

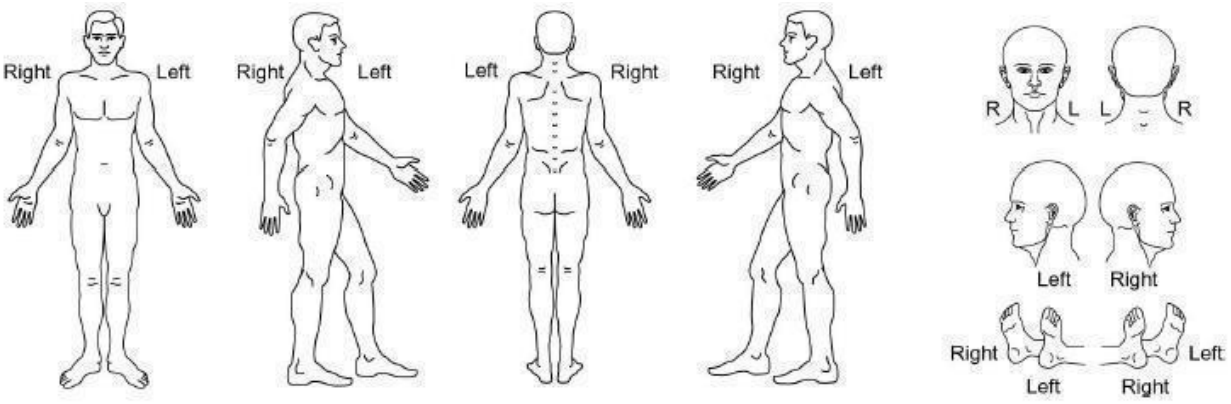
MIND BODY BABY

Reason for consultation: _____

_____

Please indicate the following:

- Site of pain "P"
- Site of restriction "R"
- Referral of pain "→"



Location of pain: L R Bilat _____

Type of pain: □ Sharp □ Dull ache □ Deep ache □ Tingling/Numb □ Other _____

When did the pain start? _____

What caused the pain? _____

Degree of pain **(Initially)**: 1 2 3 4 5 6 7 8 9 10 (1 = Mild 5 = Moderate 10 = Severe)

Degree of pain **(Now)**: 1 2 3 4 5 6 7 8 9 10 (1 = Mild 5 = Moderate 10 = Severe)

Referral of pain: _____

What aggravates the pain? _____

What alleviates the pain? _____

Irritability level: High Med Low

Other Symptoms (e.g. headaches): _____

Past / Current treatment and results: _____

Have you received a massage before? Y / N If so, what type? _____

Additional information: _____

_____

_____

MIND BODY BABY

PATIENT CONSENT

I, (Patient's Name) _____ have chosen to consult with and hereby give consent for remedial massage therapy to be provided by *Stephanie A. Simmons*.

I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.

I understand that massage may provide benefits for certain conditions, but results are not guaranteed. These benefits may include relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provisions of general wellbeing.

I also understand that massage may produce side effects such as muscle soreness, mild bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes.

I am aware that the therapist does not diagnose illnesses, prescribe medications nor physically manipulate the spine or its immediate articulations.

The therapist understands that I have the right to question procedures used and to receive an explanation of any procedure that the therapist performs.

I will tell the therapist about any discomfort I may experience during the therapy session and understand that the therapy will be adjusted accordingly.

Patient's Name (Please print): _____

Patient's Signature: _____ Date: _____

PRIVACY POLICY

MIND BODY BABY is committed to the privacy of its clients. Personal information is treated as confidential and is used only for the purpose for which it was collected.

Information kept on file will not be released to a third party without the express consent of the client or as required by law.