Guiding Waves Wellness, LLC

CLIENT INTAKE FORM

PERSONAL INFORMATION

Full Name:_____ DOB:_____

Address:_____

Phone:_____ E-mail: _____

Emergency Contact Name: _____ and Phone: _____

Occupation: _____ Date of Initial Visit: _____

Physician Name: _____ Physician Phone: _____

Referred by: _____

REASON FOR VISIT

What is the primary reason for your visit?: _____

Specific area(s) of discomfort: _____

What are your treatment goals?: _____

Have you previously experienced massage therapy or bodywork before? If so, what?:

_____

GENERAL HEALTH

How would you rate your general health?:

☐Excellent ☐Good ☐Fair ☐Poor

Physical Activity Level:

☐Daily/Regular ☐Occasional ☐Rarely/Sedentary

Daily Stress Level:

☐Low ☐Moderate ☐High/Severe

Sleep Quality:

☐Good/Restful ☐Disrupted/Light ☐Insomnia

Are you currently under medical care. Please explain if yes: _____

Hobbies/Repetitive Movements: _____

Self-Care Practices: _____

Do you have any chronic conditions that affect the quality of your daily life?: _____

_____

HISTORY OF TRAUMA

Please check all that apply to encourage and guide a safe, supportive, and trauma-informed session.

☐Car Accidents/Whiplash ☐Concussions/Head Injuries ☐Sports Injuries

☐Surgeries/Scar Tissue ☐Falls ☐PTSD ☐Chronic Long-Term Stress

☐Physical Trauma ☐Emotional Trauma ☐Psychological Trauma ☐Grief

Additional Details: _____

_____

Pressure Preference:

☐Light ☐Moderate ☐Firm/Deep

What Areas Would You Like Avoided, If Any: _____

ALLERGIES and MEDICATIONS

☐Allergies to Oils, Lotions, or Nut/Seed Products ☐Allergies to Latex/Adhesives

☐Allergies to Essential Oils/Scents

If yes, please specify allergies or hypersensitivities: _____

_____

List current medications and the conditions they are treating: _____

_____

HEALTH HISTORY Please Check All That Apply, Past and Present:

CARDIOVASCULAR

☐Congestive Heart Failure ☐Heart Disease ☐Poor Circulation ☐ Stroke

☐Low Blood Pressure ☐High Blood Pressure ☐Varicose Veins

☐Heart Attack ☐Hemophilia ☐Embolism ☐Pacemaker ☐Phlebitis

Other:_____

HEAD, NECK and CENTRAL NERVOUS SYSTEM

☐Headaches/Migraines ☐Seizures/Epilepsy ☐Recent Dental Work/Braces

☐TMJ Disorder/Jaw Pain ☐Ear Infections ☐Tinnitus/Ear Ringing ☐Stroke

☐Vertigo/Dizziness ☐Hearing Loss ☐Vision Problems ☐Contact Lenses

☐Aneurysm ☐Nerve Pain/Numbness/Tingling ☐Multiple Sclerosis ☐TBI

☐Other:_____

MENTAL HEALTH and NEUROLOGICAL DEVELOPMENT

☐Anxiety ☐Depression ☐Psychiatric Disorder ☐Stress ☐ADD

☐ADHD ☐Autism Spectrum Disorder ☐Intellectual Disabilities

☐Specific Learning Disorders ☐Communication Disorders ☐Motor Disorders

☐Other: _____

MUSCULOSKELETAL

☐Chronic Back/Neck Pain ☐Fibromyalgia/Chronic Fatigue ☐Bursitis

☐Osteoporosis/Osteopenia ☐Arthritis/Joint Pain ☐Muscle Spasms/Cramps

☐ Herniated/Bulging Discs ☐Scoliosis ☐Bone Fractures ☐Tendonitis

☐Surgical Pin/Wire/Plate/Artificial Joint ☐Other: _____

CIRCULATORY, LYMPHATIC and IMMUNE SYSTEM

☐Lymphedema ☐Lipedema ☐Edema ☐Lymph Node Removal

☐Swollen Glands ☐Blood Clots/DVT History ☐Autoimmune Disorders

☐Current Infection/Fever ☐Other:_____

RESPIRATORY

☐Asthma ☐Bronchitis ☐Sinusitis ☐Shortness of Breath ☐Smoker

☐Chronic Cough ☐Frequent Colds ☐Emphysema ☐COPD

☐Other: _____

REPRODUCTIVE

☐Pregnant, and if so, how many weeks: _____ ☐ Postpartum

☐Natural Birth ☐C-Section ☐Prolapse ☐Fibroids ☐PCOS ☐PMS

☐Painful Menstruation ☐Endometriosis ☐Other: _____

ABDOMINAL

☐Digestive Issues ☐IBS ☐Crohn's ☐Pelvic Pain ☐Hernia

Other:_____

SKIN

☐Bruise Easily ☐Eczema/Psoriasis ☐HIV/AIDS ☐Herpes

☐Lyme Disease ☐Tuberculosis ☐Hepatitis ☐Skin Rashes

☐Open Wounds ☐Recent Localized Inflammation ☐Infections Skin Conditions

Other:_____

OTHER CONDITIONS;

Cancer/Tumors ☐Active ☐Remission ☐Diabetes ☐Hormonal Imbalance

Other:_____

By signing below, I certify that the information provided above is accurate, complete and up to date. I agree to notify my practitioner of any changes in writing to my (or my child's) health status or medications prior to future sessions.

Client Name (Printed): _____

Client Signature: _____ Date: _____

* If Under 18, Client Name (Printed): _____

* Parent/Legal Guardian Name (Printed): _____

* Parent/Legal Guardian Signature: _____ Date: _____