Le Soleil Health & Wholeness Massage Therapy Client Treatment Intake Form

Name: _____ Pronoun:_____

Phone (Cell): _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ Postal Code: _____

Emergency Contact (Name/Phone): _____

E-mail:_____Occupation:_____

Have you received a massage before? Y / N

Are you currently receiving treatment(s) from other healthcare professionals? Y / N

If YES, please identify the type of health care professional and what condition you are being treated for?

_____

Do you have any allergies or hypersensitivity reactions? Y / N

If "Yes", what triggers a reaction? _____

Do you carry an Epi Pen and/or any emergency medications? Y / N

If "Yes" please indicate the type of medication _____

GENERAL INFORMATION:

- **Does your sleep quality affect your daily activities?** Y / N

If "Yes" please describe _____

- **Please list any serious or lasting physical trauma's (injuries, accidents, incidents)**

Date	**Description of Trauma**

- **Please list any surgeries**

Date	**Description of Surgery**

Are you currently, or have you ever received treatment for any of the following conditions:

CARDIOVASCULAR

- ❑ Stroke Date:_____
- ☐ Heart Attack Date:_____
- ❑ Low Blood Pressure
- ❑ High Blood Pressure
- ❑ Phlebitis
- ☐ Heart Disease (heart valve/ pacemaker/ similar device)
- ☐ Dizziness/Vertigo
- ☐ Varicose Vein
- ☐ Chronic Congestive Heart Failure
- ☐ Other_____

List any medications taken for these conditions:_____

SKIN

- ❑ Eczema
- ❑ Warts
- ❑ Contact Dermatitis
- ☐ Herpes
- ☐ Athletes foot
- ☐ Other_____

List any medications taken for these conditions:_____

DIGESTIVE

- ❑ Crohn Disease
- ❑ Constipation
- ❑ Colitis
- ☐ Ulcers
- ☐ IBS
- ☐ Other_____

List any medications taken for these conditions:_____

RESPIRATORY

- ❑ Chronic Cough
- ❑ Asthma
- ❑ Emphysema
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Other_____

List any medications taken for these conditions:_____

MUSCLE, JOINT & BONE

- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ☐ Scoliosis
- ☐ Other_____
- ☐ Wires/Plates/Pins Location:_____
- ☐ Fractures/Sprains Location:_____

List any medications taken for these conditions:_____

NEUROLOGICAL

- ❑ Epilepsy/Seizures
- ❑ Parkinsons Disease
- ☐ Multiple Sclerosis
- ☐ Alzheimer/Dementia
- ☐ Other_____

List any medications taken for these conditions:_____

HEAD & NECK

- ❑ History of headaches
- ❑ History of migraine headaches
- ☐ Vision Loss/condition
- ☐ Dizziness/Vertigo
- ☐ Hearing Loss/condition
- ☐ Concussion Date:_____
- ☐ Whiplash Date:_____
- ☐ Other_____

List any medications taken for these conditions:_____

MENTAL HEALTH

- ❑ PTSD
- ❑ Anxiety
- ☐ Depression
- ☐ Other_____
- ☐ On a scale of 1-10, please indicate your current stress level (1= no stress 10= extremely stressed) _____

List any medications taken for these conditions:_____

OTHER CONDITIONS

- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Chronic Fatigue Syndrome
- ❑ Hepatitis
- ❑ Autoimmune Type(s):_____
- ❑ Cancer Type(s):_____ Date(s):_____
- ❑ Loss of Sensation
  Please indicate location(s):_____
- ❑ Tingling/Numbness
  Please indicate location(s):_____
- ❑ Pregnancy _____WKS ☐Complications
  Please provide details of complications:_____
- ☐ HIV/Aids
- ☐ Long Covid
- ☐ Kidney Disease
- ☐ Hemophilia

List any medications taken for these conditions:_____

Please list any other medical conditions not listed above, that you are currently living with or have dealt with in the past.

_____

_____

Your comfort and trust in this practice is very important. You are strongly encouraged to communicate with your therapist before, during & after your treatment about any aspect of the treatment. To assist in ensuring your comfort, please answer the following:

During my treatment I prefer to (circle one)

*Remain silent to enjoy some quiet & down time *Chat casually throughout the session *Follow the lead of the therapist

Other (please specify)_____

On a scale of 1 -10, please indicate the type & depth of pressure you generally prefer to receive during your treatment (1- very light pressure 5 - moderate pressure 10 very deep pressure) _____

General feedback regarding preferred pressure/techniques_____

I acknowledge that:

- I have read, understood and completed, to the best of my knowledge, the client history form.
- I have informed the therapist/practitioner of all my known physical &, medical conditions and medications and I will keep the them updated on any changes to my health history
- All information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information
- Massage is not a substitute for medical treatment or medications, and that it is recommended that I work concurrently with my primary caregiver for any conditions I may have.
- The therapist/practitioner does not diagnose illness, disease or any other physical or mental condition and does not prescribe medications
- I release the therapist/practitioner and all affiliates from any liability, past, present or future relating to treatment received at this clinic and from problems arising from the treatment or as a result of information not given or incorrectly given in this health history.

Cancellation Policy: In order to offer the best service to clients who may be in need of treatment, a 24 hour cancellation policy has been implemented. Any appointments with less then 24 hours notice of cancellation, may be subject to a cancellation fee (not to exceed the cost of the missed treatment) at the discretion of the therapist.

I am aware of and agree to abide by this cancellation policy _____ (please initial here)

Printed Name (client):

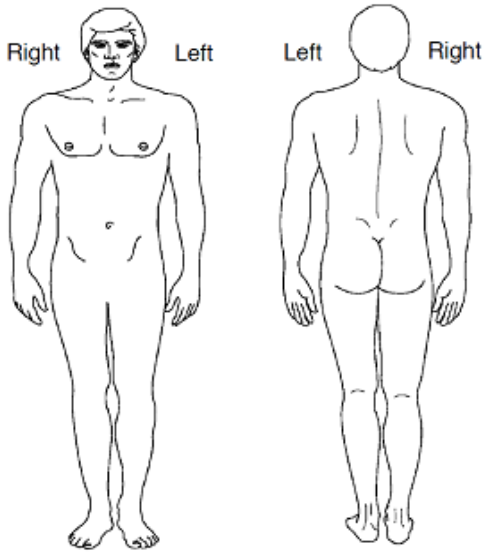
_____

Signature (client):

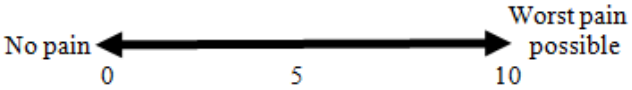
_____

Date: _____

Use this diagram to indicate areas where you have your pain.



Pain Intensity:
Please use the pain scale described below to rate your pain for the questions below:



FUTURE HEALTH HISTORY REVIEWS:

Reviewed & Renewed on (Date):_____ Client Signature _____

Reviewed & Renewed on (Date):_____ Client Signature _____

Reviewed & Renewed on (Date):_____ Client Signature _____

Reviewed & Renewed on (Date):_____ Client Signature _____