



James Stevenson

Myotherapist

Body Therapy that Works!!



Client Intake

ALL fields are **required** so that I may provide care **safely and effectively**.
Please feel free to ask for assistance. Thank You.

Client's Name: _____ Date: _____

Address: _____

Email: _____ Phone (day): _____ Phone (eve): _____

Occupation: _____ Hobbies: _____

Referred by: _____ Birthdate: _____ Site: _____

Please give a brief summary of any previous massage experience you've had: _____

List any Injuries, Surgeries, Accidents and treatment received with dates: _____

List any medical or back problems you currently have or have had: _____

List any medications (prescription or non), drugs, herbs, vitamins, or supplements you are taking or have taken in the last 90 days or took for more than three months duration previous to that: _____

Are you currently under medical care or advisement for any illness, injury or condition? If so, please describe.

If you are having any difficulties with the following Systems and/or if you have or suspect you may have any of the following Conditions or Symptoms, please check off any that apply and write more specific detail on the back of this form.

SYSTEMS	OTHER CONDITIONS	SYMPTOMS
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Allergies	<input type="checkbox"/> Abnormal energy
<input type="checkbox"/> Endocrine	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bruises or Bleeding
<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Cancer	<input type="checkbox"/> Dietary problems
<input type="checkbox"/> Immune	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Headaches
<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Inflammation
<input type="checkbox"/> Neurological	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Psychological	<input type="checkbox"/> _____	<input type="checkbox"/> Numbness
<input type="checkbox"/> Reproductive	<input type="checkbox"/> _____	<input type="checkbox"/> Pain (where?)
<input type="checkbox"/> Respiratory	<input type="checkbox"/> _____	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Urinary	<input type="checkbox"/> _____	<input type="checkbox"/> Sleep problems
	<input type="checkbox"/> _____	<input type="checkbox"/> Stress

Comments, Questions or Concerns: _____

Client Informational Statement: I understand that I will be receiving a therapeutic massage and that the purpose of this massage is to maintain good health and physical condition. I understand that massage therapists may not diagnose nor treat any injuries nor disease and that massage should not take the place of a doctor's care, where indicated. I have made full disclosure of all medical conditions, symptoms, treatments and care I am or have been under to the best of my knowledge and ability. All records are treated as highly confidential and, other than in the form of aggregate anonymous statistics, will not be released to anyone for any reason without express written consent of the client (or client's guardian in case of client under age of 18) or by court command. James Stevenson reserves the right to refuse service to anyone.

Client or legal guardian if client under 18 years of age:

Signed: _____

Date: _____