Gary L. Wass, LMT
Client Intake

Date: _____

Patient Name: _____ Birthdate: _____ Male_____ Female _____

Address: _____

City: _____ St.: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

Primary Care or Referring Physician _____

Email: _____ Appointment Reminder by email? Yes___ No___

How did you hear about us? _____ Have you had a massage before?: _____

What complaints, symptoms are you experiencing that made you seek therapeutic body work?

_____

Are there any areas of your body you prefer **NOT** to be worked on at this time?

_____

Rate your pain scale from (1 is mild, and 10 extreme) _____

1 2 3 4 5 6 7 8 9 10

Rate your current life situation in terms of stress: (1 is peaceful, 10 is very stressed):

1 2 3 4 5 6 7 8 9 10

What types of regular exercise do you participate in and how often? _____

_____

Please circle the following:

Are you wearing contacts?		Yes	No
Are you pregnant?	If yes, wks. _____	Yes	No
Do you have any contagious skin diseases?		Yes	No
Have you recently been hospitalized, ill or injured? If yes, Explain:		Yes	No

_____

Are you taking any medications? If so, please list name of medication and condition it is treating:

_____

Do you sit for long hours at a workstation or computer?	Yes	No
Do you perform any repetive movement in your work, sports?	Yes	No
Do you have difficulty laying on your front, back or side?	Yes	No

Please Explain: _____

Check any of the following conditions you have had in the past, currently have or are being treated for:

☐ Headaches	☐ Skin Disease	☐ Diabetes
☐ Eye Strain	☐ Compromised Immunity	☐ Back Problems
☐ Sinus Problems	☐ Blood Clots	☐ Fractures
☐ TMJ	☐ Vericose Veins	☐ Torn Cartilage
☐ Arthritis	☐ High/Low Blood Pressure	☐ Dislocated Joints
☐ Seizures	☐ Heart Problems	☐ Allergies
☐ Cancer	☐ Communicable Disease	☐ Asthma
☐ Digestive Problems	☐ Eating Disorders	☐ Others please list:
☐ Ulcers	☐ Kidney Disease	_____