Living Kinetics Health Intake Form

Client Contact Information

Client First Name: ______________________ M: __________ Last Name: ______________________ Date of Birth: _______________

Gender: ________ Address: ____

City: ____________________________ State:____________________________ Zip Code: ____________________________

Phone: ______________________________ Email: ____

Occupation:____________________________ Can we contact you through text? Yes ☐ No ☐ Referred by: ______________________

Emergency contact: ____ Phone: __________________________________

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐ What kind of pressure do you prefer? Light Medium Firm

Do your symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes ☐ No ☐ , If yes, please explain:

____

List the medications you currently take:

____

Are you wearing contacts? Yes ☐ No ☐ Are you pregnant? Yes ☐ No ☐, If yes, expected due date:_________________________

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

____

Please indicate conditions that you have or have had in the past:

Muscle or joint pain ____________________Muscle or joint stiffness ____________________Numbness or tingling _______________

Swelling ____________________________Bruise easily ____________________________Sensitive to touch/pressure ___________

High/Low blood pressure _________________Stroke, heart attack ______________________Varicose veins, blood clots ____________

Shortness of breath, asthma _______________Cancer ________________________________Neurological ____________________

Headaches, Migraines ___________________Dizziness, ringing in the ears _________________Digestive conditions ________________

Gas, bloating, constipation ________________Kidney disease, infection ___________________Arthritis ________________________

Osteoporosis, degenerative disk _____________________Scoliosis _____________________Broken bones ____________________

Allergies _____________________________Diabetes ______________________________Endocrine/thyroid conditions __________

Depression, anxiety ____________________Memory Loss, confusion, easily overwhelmed ____________________________________

Comments: ____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: ____ Date: ______________________

Parent or Guardian Signature (in case of a minor): ____ Date: ______________________