West Linn Holistic Center

Client Intake Form

First & Last Name _____
Date of Birth _____
Email Address _____
Mobile Phone # _____
Street Address _____
City _____ Zip _____
Emergency Contact Name & Phone _____
Physician Name & Phone _____
How did you hear about us? _____

Please check any symptoms or conditions that you are currently experiencing:

Head/Neck
- ☐ Headaches/Migraines
- ☐ Ringing in Ears
- ☐ Vertigo/Dizziness
- ☐ Vision Problems
- ☐ Hearing Loss
- ☐ Vision Loss

Respiratory
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Smoker
- ☐ Other_____
  _____

Nervous System
- ☐ Sciatica
- ☐ Seizures
- ☐ Numbness/tingling
  Location:_____
  _____
- ☐ Multiple Sclerosis

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Pins/plates/wires/artificial joint
- ☐ TMJ
- ☐ Scoliosis

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Stroke
- ☐ Poor Circulation
- ☐ Pacemaker
- ☐ Varicose Veins
- ☐ Blood Clots

Skin & Infections
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Lyme Disease

Reproductive
- ☐ Currently Pregnant
- ☐ Given Birth

Other Conditions
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive Conditions
- ☐ Fibromyalgia
- ☐ Other_____
  _____
  _____
  _____
  _____
  _____
  _____

Please list & date any major surgeries or accidents:

Please list any medications, including aspirin, herbs & supplements:

Are you allergic to any food, nuts, fragrances, or other?

Have you been seen by a massage therapist before? When?

I confirm that the information provided is true and accurate. Massage therapists are not liable for any withheld information. I am aware of the benefits and risks of massage therapy. I acknowledge massage therapy is not a substitute for medical care, medical examination, or diagnosis. I give my consent to receive massage therapy.

Signature _____ Date _____