be Well
1032 Goodlette-Frank Rd N • Naples, FL 34102
Clinic phone: 239.307.5616 • bewellnaples.com

MASSAGE client intake form

Be Well LLC: MM34810

Today's date (date of initial visit)

personal information

name

address

city state zip

home phone

cell phone

email

occupation

marital status if married, spouses name

referred by

emergency contact name (relationship) emergency contact phone

massage experience

Have you had a professional massage before? ☐ Yes ☐ No

If yes, what type of massage do you prefer (swedish, shiatsu, deep tissue, etc.)?

How long have you been receiving massage therapy? _____

Frequency of massages? _____

Are you currently receiving treatments or under the care of a:

☐ Chiropractor ☐ Acupuncturist ☐ Physical therapist ☐ Other

What are your goals for this treatment? _____

current health

Date of birth/current age: _____

Height & weight _____

Do you exercise regularly and/or participate in any sports?

☐ Yes ☐ No If yes, what kind of exercise/sports?

Do you perform any repetitive movement in your work, sports or hobby? ☐ Yes ☐ No Comments or description: _____

Do you sit for long hours at a workstation, computer or driving?

☐ Yes ☐ No Comments or description: _____

Are you experiencing unusual stress in your work, family, or other aspect of your life? ☐ Yes ☐ No

Do you clench your jaw or grind your teeth when tense? ☐ Yes ☐ No

Are you experiencing tension, stiffness, discomfort or pain?

☐ Yes ☐ No If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation?

☐ Yes ☐ No If yes, describe _____

Do you have sensitive skin? ☐ Yes ☐ No

Do you have any allergies to nuts, oils, lotions or ointments?

If yes, please explain _____

List any medications you are currently taking

List any known allergies _____

health history - please note "c" for current or "p" for past year. This information helps us identify safe protocols for you.

Musculoskeletal
___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory
___ Heart Condition / Pacemaker
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Reproductive
___ Pregnant, stage _____
___ Ovarian/Menstrual Problems
___ Organ Prolapse
___ Hypertonic pelvic

Respiratory
___ Breathing Diffculty/Asthma
___ Emphysema
___ Allergies, specify: _____
___ Sinus Problems

Nervous System
___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Digestive
___ Irritable Bowel Syndrome
___ Bladder/Kidney Ailment
___ Colitis
___ Crohn's Disease
___ Ulcers

Skin
___ Allergies, specify: _____
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores
___ Areas contraindicated for massage

Other
___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol
___ Contact Lenses
___ Dentures
___ Hearing Aids
___ Anxiety/Stress
___ Depression
___ Fibromyalgia
___ Immune_____
___ _____

Any other medical condition(s) not listed: _____

Dates or explanations for conditions that you have marked:

intake form cont'd, client agreement & health release form

client name _____ date _____

reason for your visit, symptoms and concerns

Are you here for manual lymph drainage due to recent surgery or thermographic test findings? ☐ Yes ☐ No

If yes please provide date and description of surgery or thermogram

_____

May we use your thermogram to guide treatment? ☐ Yes ☐ No

Are you here for ☐ scar ☐ cellulite or ☐ anti-aging treatments?

Describe: _____

Have you had a pain evaluation by thermography? ☐ Yes ☐ No

If yes, may we use your thermogram to guide treatment? ☐ Yes ☐ No

Is your condition the result of a recent accident or injury?

☐ Yes ☐ No If yes, which if the following apply?

☐ auto accident ☐ personal injury ☐ other
☐ work injury ☐ sports injury

Date & description of injury: _____

_____

Is your condition the result of a past accident or injury?

☐ Yes ☐ No If yes, please describe

_____

_____

Do you know what triggered the pain? ☐ Yes ☐ No

If yes, please describe _____

_____

Does anything relieve it? ☐ Yes ☐ No If yes, please describe

_____

_____

Does anything aggravate it? ☐ Yes ☐ No If yes, please describe

_____

_____

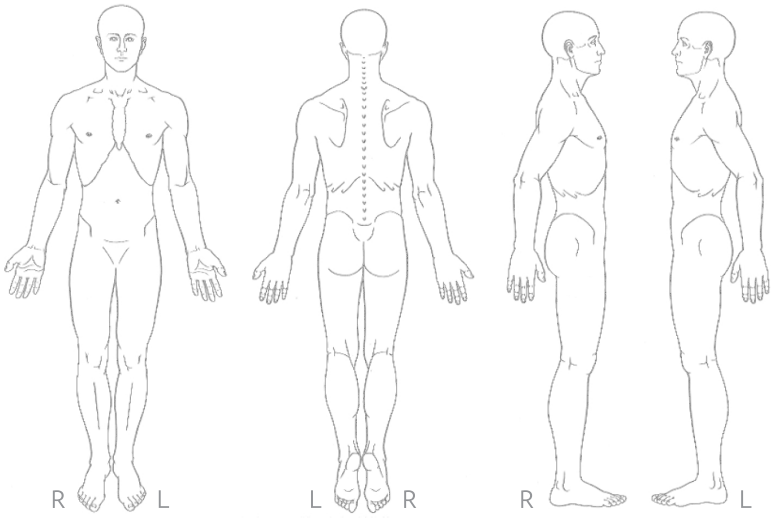
Any additional comments to help us help you?

_____

_____

On the diagrams below, please indicate areas of:

X Worst Pain	::: Pins & needles
O Secondary Pain	> Skin lesions / scaring
/// Numbness	+ Injury, fractures or surgery



client agreement/contract for care

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

_____

signature *REQUIRED* date

_____

signature of parent or legal guardian (if client if a minor)

privacy

The information collected on this form is confidential and will be stored in a secure location. We will not share any information without your consent. Information (such as email) entered into our scheduling software will be used to contact you with appointment reminders and our special offers. You may opt out of receiving promotional emails at any time by clicking on the link provided in the email or by emailing info@bewellnaples.com. Full privacy policy information can be accessed on our website bewellnaples.com

release of medical records (if desired)

who is your attending physician?

_____

name

_____

address

_____

city state zip

_____

office phone email

Permission to consult with _____ regarding _____ your initials_____

Has an attorney been retained? ☐ Yes ☐ No

_____

name

_____

address

_____

city state zip

_____

home phone work phone

_____

email

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.

_____

signature date

_____

signature of parent or legal guardian (if client if a minor)

Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.