Selkie Botanicals

# New Client Intake Form

## Client Contact Information

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|---|---|
| **Today's Date:** | |
| **First Name:** | |
| **Last Name:** | |
| **Date of Birth:** | |
| **Pronouns (she/he/they):** | |
| **Phone Number:** | |
| **Email:** | |
| **Address:** | |
| **Emergency Contact Name:** | |
| **Relationship to Emergency Contact:** | |
| **Emergency Contact Phone Number:** | |
| **Referred by:** | |

## Massage Information

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| **Have you received a professional massage or body work before?** | Yes / No |
| **If yes, what type of massage have you received? Please describe:** | |
| **What is your focus area?** | |
| **Where do you hold tension/stress?** | |
| **How do you feel today?** | |

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| **List and prioritize your current symptoms/issues (stress, pain, stiffness, anxiety, etc)** | |
| **Do these symptoms interfere with your activities of daily living? (sleep, exercise, work, driving, childcare, etc). If yes, please describe:** | |
| **List the medications you currently take:** | |
| **What are the medications for?** | |
| **Do you have any bolts, screws, plates, or a heart monitor in your body? If yes, please describe:** | |
| **Are you pregnant? If Yes, how far along are you?** | |
| **Have you had any injuries or surgeries in the past that may influence today's treatment? If yes, please describe.** | |

## Healthy History

| (Put and "X" under Current or Past) | Current | Past |
|---|---|---|
| **Muscle or joint pain** | | |
| **Muscle or joint stiffness** | | |
| **Numbness or tingling** | | |
| **Swelling** | | |
| **Bruise Easily** | | |
| **Sensitive to touch or pressure** | | |
| **High or Low Blood Pressure** | | |
| **Stroke** | | |
| **Heart Attack** | | |

| (Put and “X” under Current or Past) | Current | Past |
|---|---|---|
| Varicose Veins | | |
| Shortness of breath / Asthma | | |
| Cancer | | |
| Neurological Conditions (MS, Parkinson’s chronic pain) | | |
| Epilepsy (seizures) | | |
| Headaches, Migraines | | |
| Dizziness, ringing in ears | | |
| Digestive Conditions (Crohn’s, IBS) | | |
| Gas, Bloating, Constipation | | |
| Kidney Disease, Infection | | |
| Arthritis (Rheumatoid, Osteoarthritis) | | |
| Scoliosis | | |
| Broken Bones | | |
| Allergies | | |
| Diabetes | | |
| Endocrine / Thyroid Conditions | | |
| Athletes Foot | | |
| Depression | | |
| Anxiety | | |
| Memory Loss, Confusion, Easily Overwhelmed | | |

Comments:

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## Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the Therapist 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, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork therapist 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 therapist 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.

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| **Client First & Last Name Printed:** | |
| **Client Signature:** | |
| **Parent or Guardian Signature (in case of a minor):** | |
| **Date:** | |