Serendipity

Massage Therapy & Bodywork
39 - 3rd Avenue, Sturgeon Bay, WI 54235

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National Board Certified Massage Therapist & Bodyworker

Client Health Intake Form – Ashiatsu Specific

Thank you for your visit. I sincerely hope based upon my experience and certified training, that the massage you receive will help you on your way to a more relaxed, healthy and sound way of living.

Please take a few minutes to fill out this form. It will enable me to give you the therapy best suited for your specific needs. If you have an existing medical condition you feel may be adversely affected by massage, please feel free to telephone your physician prior to your massage. I encourage you to do so; a relaxed mind is the beginning of a wonderful massage!

Name _____

Address_____ City/State/Zip_____

Phone_____ E-mail_____

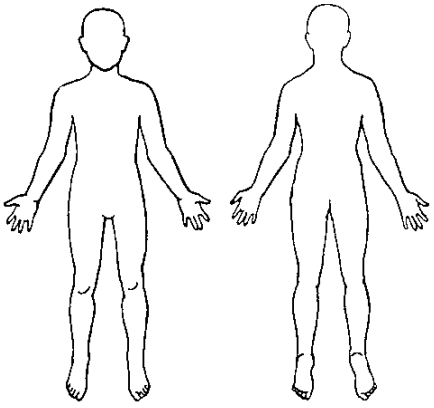
Occupation_____ Birthday_____

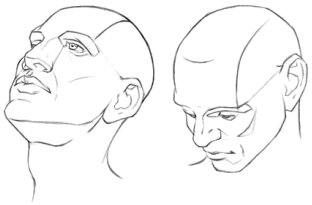
Are you 18yrs of age or older? (Yes) (No) Whom may I thank for this referral?_____
Have you had a professional massage before? (Yes) (No)

Have you had or do you have any of the following – please check:

- ☐ Skin condition (Acne, rash, skin cancer, other)
- ☐ Lymphatic condition (swollen glands, Lymphoma, Lymph edema, other)
- ☐ Recent injury (whiplash, sprain, deep bruise, other)
- ☐ Recent knee or hip injury
- ☐ Recent injections at a joint or muscle junctures (cortisone, Botox)
- ☐ Recent eye surgery (Lasik in the past 72 hours)
- ☐ Circulatory condition (heart disease, high blood pressure, varicose veins, arrhythmia, Thrombosis, arteriosclerosis, pacemaker, stint, or shunt)
- ☐ Boils or Abscesses
- ☐ Diabetes
- ☐ Low blood sugar
- ☐ Aneurysm
- ☐ Irritable bowel syndrome
- ☐ Kidney disorder
- ☐ Joint stiffness or joint pain
- ☐ Tendency for headaches
- ☐ Dislocation of shoulder
- ☐ Pregnancy or trying to get pregnant
- ☐ Heavy or unusual menstrual flow
- ☐ Breast or any other implants within the last year
- ☐ Bone conditions (osteoporosis, rib fracture, cancer, or other)
- ☐ Neurological condition (sciatica, numbness/tingling, Stroke, or epilepsy)
- ☐ Emotional difficulties (depression, anxiety, other)

Circle areas of pain





Previous surgeries (date and type)_____

Are you taking any of the following medications?
☐ Coumadin ☐ Lavonox ☐ Heparin ☐ Heavy aspirin ☐ Other

Name of Health Care Provider (Doctor)_____ Phone_____

You have my permission to contact my healthcare provider should the need arise.

Signature:_____ Date:_____