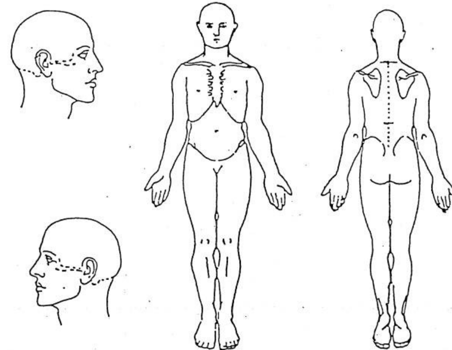
Client Health Intake Form – (Ashiatsu Specific)

Name____
Address____
____
Phone_________________Evenings_________________
Occupation____________________Birthday____________
Referred By_______________________________________
Have you had a professional massage before?___________

PLEASE CHECK IF YOU HAVE, OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

___ 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)
___ Previous surgeries (please state date and type)

Circle areas of pain



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 health care provider should the need arise.

Signature______________________________ Date___________________________