Client Intake Form

Name

DOB

Occupation

Address

City, State, Zip

Phone

E-mail

For future scheduled appointments I can be reached by

☐ Phone ☐ Text ☐ email

Emergency Contact & Number

Have you received massage therapy before?

Frequency

◯ Yes ◯ No

Ashiatsu Oriental Bar Thearpy (AOBT)

Frequency

◯ Yes ◯ No

Today Primary Concern or Goal

Do you experience or have any of the following

☐ Pain, Tenderness ☐ Numbness, Tingling ☐ Swelling, Stifness

Rate severity of symptoms from 1-10

	1	2	3	4	5	6	7	8	9	10
Minor - extreme	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Are you under a Doctor, Chiropractor, Acupuncturist or other health care practitioners care? Please Explain

List current medication (including over the counter and herbal remedies)

Check any of the following that apply to your current health

- ☐ Heart Conditions
- ☐ Diabetes
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Skin Condition
- ☐ Asthma
- ☐ Sciatica
- ☐ Arthritis/Joint
- ☐ Circulator Condition
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis/Emboli
- ☐ Stroke
- ☐ Epilepsy
- ☐ High/Low Blood Pressure
- ☐ Other

Women Are you pregnant

How Many Weeks

◯ Yes ◯ No

List any major surgeries in the last 24 months (type/date)

Accidents (type/date)

Consent for Care

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

Signature (type in full legal name for digital signature) Date