You Center Wellness

Client Intake Form

Name:_____ Email: _____
Cell Phone: _____ DOB (month/day/year): _____/_____/_____ Age: _____
Address: _____ City/State/Zip: _____
Emergency Contact Name: _____ Phone: _____ Relationship: _____
Occupation: _____ Referred by/How you heard of us: _____

What is your major complaint / What brings you here? _____
_____

List Allergies? (Oils, nuts, herbs, lotions, skin sensitivity, etc?) _____

Are you currently pregnant? YES NO
I agree to inform my therapist of pregnancy before scheduling or receiving treatments in the future. *Initial* _____

Injuries or medical procedures in the past 2 yrs? YES NO _____
_____

Are you currently taking any medications? YES NO (if yes, please list) _____
_____

Are you currently under medical supervision or receiving other medical interventions? YES NO
If yes, please describe _____
_____

Massage Information:

Have you had a professional massage before? YES NO How Recently? _____

Reason for seeking massage? _____

How much pressure do you prefer? Light Medium Firm Deep Not Sure

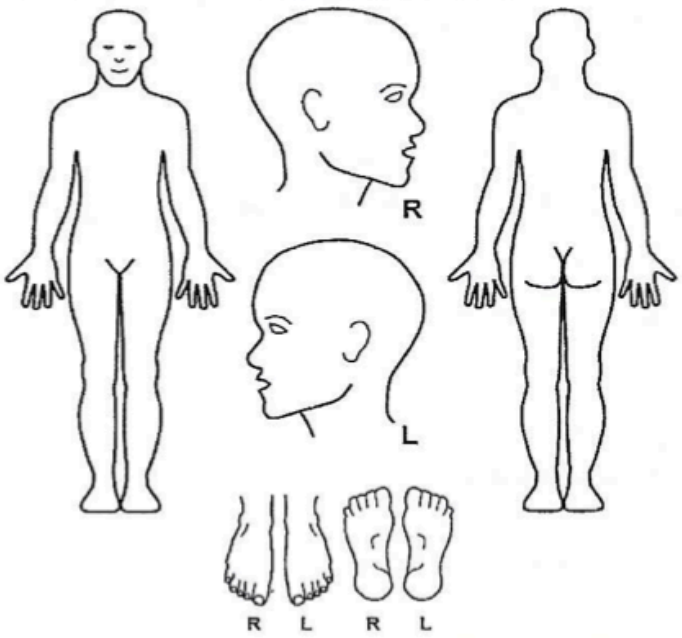
Please look at the figures at the right.

Please mark the figures using the key below the image.

Note the severity of pain or tenderness using a 0-10 pain scale. On the scale, 0 is no pain and 10 is the worst pain.

Describe any other concerns, areas you would like me to address or avoid.

_____
_____
_____
_____
_____
_____



Health Information

Do you currently, or have ever, had any of these conditions? Please circle Yes or No for each item.

Anxiety / Stress	Yes	No	Osteoarthritis	Yes	No	Stroke / CVA	Yes	No
Depression	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Fibromyalgia	Yes	No	Vertigo	Yes	No
Bleeding Disorder	Yes	No	Rheumatoid Arthritis	Yes	No	Hearing Loss	Yes	No
Blood Clot	Yes	No				Vision Impairment	Yes	No
Bruise Easily	Yes	No	Circulatory Problems	Yes	No	Frequent Headaches	Yes	No
High Blood Pressure	Yes	No	Seizure / Epilepsy	Yes	No	Ulcers	Yes	No
Low Blood Pressure	Yes	No	Bursitis	Yes	No	Indigestion / Bloat	Yes	No
Varicose Veins	Yes	No	Cancer / Tumor	Yes	No	Loose Stool	Yes	No
Muscle Weakness	Yes	No	Diabetes	Yes	No	Constipation	Yes	No
Tendonitis	Yes	No	Kidney Disease	Yes	No	Excess Belching / Flatulence	Yes	No
Neropothy	Yes	No	Multiple Sclerosis	Yes	No			
TMJ	Yes	No	Sciatica	Yes	No	Surgery	Yes	No

Notes for above:

Pain that radiates down your arms or legs?	Yes	No	
Chronic pain?	Yes	No	
Implants, devices or artificial joints?	Yes	No	
Back, spinal, or neck problems?	Yes	No	
Broken skin, wounds, rash?	Yes	No	
Areas of swelling?	Yes	No	
Areas of numbness?	Yes	No	

I understand that the services provided at You Center Wellness, LLC are complementary and should not be considered a substitute for medical or psychiatric care. The massage therapy offered here is intended for stress and pain reduction, relief from muscular tension or spasms, and to enhance circulation and energy flow. All Ayurveda information provided is for educational purposes only, and Ayurveda consultations and treatments are not intended to diagnose, treat, or cure illnesses. Prior to implementing any recommendations or treatments, I agree to consult with my medical doctor regarding my medical needs and Ayurveda knowledge.

During any service or interaction, I agree to promptly inform my wellness advocate/therapist of any discomfort or concerns that may arise.

I understand that my personal and health information has been collected and will be kept confidential, unless required by law or in the event of a medical emergency. In case of a medical emergency or suspicion of one, I acknowledge that 911 may be contacted on my behalf, and I will be responsible for any associated fees. I confirm that I have provided complete and accurate medical information, and I will inform You Center Wellness, LLC promptly of any changes in my condition.

Signature Date