Jeff Wells, LMBT (NC#2252)
Wellsport Bodyworks
Confidential Client Intake Form

Name _____
Address _____ Home Phone _____
City/State_____ Work Phone _____
Zip _____ Occupation _____
Date of Birth ____/____/____ Email_____

Have you ever had professional body work/massage?_____

What are your intentions for this session? _____

_____

Primary area of complaint? _____

How did this develop? _____

What makes it worse/better _____

Describe your activities at work/home. _____

What are your short term and/or long-term goals regarding your body? _____

_____

How do you feel about your general health? _____

Please check if you wear: __ Contact lenses __ Dentures __Hair piece/wig

Medical Information

Doctor's name(s) and phone number(s) _____
_____

Have you had any recent injuries, surgeries, or hospitalizations? _____
_____

Are you taking any over the counter prescriptions, medications or supplements?_____
_____

Do you follow a special diet? _____

Please check any condition(s) that apply to you:

__Muscular Injuries/Diseases	__Migraines/Headaches	__Digestive
__Spinal/ Skeletal	__Neurological	__Constipation
__High/Low Blood Pressure	__Arthritis	__Dizziness
__Blood Clots	__Allergies	__Menopausal
__Heart Disease	__Asthma	__Skin Problems
__Circulatory	__Cancer	__Sleeping Problems
__Diabetes	__Abdominal Pain	__Depression/Mental Disorder
__Anxiety	__Chest Pain	__Hernia/Rupture
__Swelling/Edema	__Infection of any kind	__Fatigue

Other Problems _____

Please see other side of form for important information

Client Agreements

Because a massage therapist
must be aware of any existing physical conditions
that I have, I have listed all my known medical conditions
and limitations and I will inform my therapist of any changes
in my physical health.

I understand and agree that:

1. The massage that I am given is for the purpose of stress reduction, relief from muscular tension/spasm and /or for improving circulation.
2. A massage therapist neither diagnosis illnesses, disease, or any other medical, physical or mental disorders, nor performs any spinal manipulations.
3. I am responsible for consulting a qualified physician for any physical ailments that I may have.
4. If I should make advances toward the service provider or have sexual intentions relating to the session the therapist has the right to terminate the session.

I agree that all services rendered to me are charged directly to me and
I am responsible for payment unless prior arrangements
have been made. I agree to pay in full for all scheduled
appointments that I am unable to keep unless
I notify my therapist
at least 24 hours in advance.

Signature_____

If under 18 years of age
Parent or guardian must sign _____

Date _____