Awaken Wellness, LLC
7130 Minstrel Way, Suite 160
Columbia, MD 21045
Acupuncture, Chinese Herbal Medicine, Massage Therapy, & Yoga
(410) 312 9922
AwakenWellnessColumbia.com

Confidential Client Intake – Therapeutic Massage

♥ **Full Name:** ____ **Date:** ________________

♥ CONTACT INFO

Email: ______________________________________ **Birthdate:**____/_____/______

Phones (C): _(______)________________(H):_(_____)_______________ **(W):** _(______)______________

Street Address: ____

City: ____ **State:** ____________ **Zipcode:** __________________

♥ EMERGENCY CONTACT INFO

Emergency Contact - Name: ____

Contact Phone: _(______)________________________________**Relationship:** ________________________

♥ REFERRAL

Referred by? ________________________

How did you hear about Awaken Wellness? ____

____

♥ MASSAGE EXPERIENCE

What results do you hope to achieve from receiving massage?

____

____

Have you ever had a professional massage or other type of bodywork? **Circle one:** YES / NO

If Yes, when was your last session: ____

What kind (s)? ____

____

♥ PERSONAL INFORMATION

Your Occupation: ____

Estimate your current Stress Level from lowest (1) to highest (10):________________________________

Do you Smoke? YES / NO **Wear Contact Lenses?** YES / NO **Wear Dental Pieces?** YES / NO

If you exercise or are active regularly, list what you do and how frequently:

____

____

♥ MEDICAL CONSIDERATIONS

Are you presently under the care of a physician or therapist? Circle one: YES / NO

If so, for what? ____

____

If you have allergies, list to what you are allergic and your reaction:

____

____

Please list any medication(s) or supplements you are presently taking and the reasons you are taking them. ____

____

List any side effects you may experience: ____

____

____

For women, is there a chance you are pregnant? Circle one: YES / NO
If so, how many weeks are you? ________________

♥ OTHER CONSIDERATIONS

Is there anything else in terms of your health or well-being that you feel your therapist should know before you begin your session?

____

____

Please CIRCLE any of the following conditions you currently have or have experienced in the past.

Today, are you experiencing:	Have experienced in your past:	Have experienced in your past:	Have experienced in your past:
Sunburn	Depression/Acute Anxiety	TMJ/Jaw Pain	Pace Maker Implanted
Inflammation	Fungal Infections	Sprains, Strains	Kidney/Gall Stones
Severe pain	Herpes Simplex	Tendonitis	Multiple Sclerosis
Headache	Warts	Carpal Tunnel Syndrome	Weakness
Open cuts, bruises or burns	Burns	Diabetes	Numbness
Irritated skin rash	Edema	Sciatica	Headaches
Poison ivy/Poison oak	Mononucleosis	Spine Problems	Migraines
Cold/Flu	Hepatitis	Scoliosis	Stroke
Muscular Soreness	Lupus	Pregnancy	Seizure Disorders
Menstrual Cramps	Shingles	Endometriosis	Restless Leg Disorder
Back Pain	Digestive Complains	Breast Augmentation	Emphysema
Nail Fungus	Abdominal pain	Anemia	Asthma
Athletes Foot	Fibromyalgia	Blood Clots	Hay Fever
Pregnancy	Arthritis	Low/High Blood Pressure	Sinusitis
Gastric Distress	Bursitis	Varicose Veins	Cancer of any kind (list below)
Chest Pain	Osteoporosis	Circulatory Problems	______________________

Please mark areas of pain or discomfort

Pain and tenderness = O
Numbness and tingling = ZZ
Swelling and stiffness = X