CLIENT INTAKE FORM

Name _____ DOB _____ ❑ Male ❑ Female

Address _____ Weight : Height :

Phone _____ E-mail: _____

Occupation _____

Emergency contact _____ Phone _____

Have you received massage therapy or bodywork before? Yes No

Are you on any medication? Yes No If yes, which ones _____

Do you exercise? Yes No If yes, how many times per week ? _____ How many hours? _____

**Please take a moment to carefully read the following information and choose the answers that relate to you the most. You can elaborate on your answers. Please sign where indicated.

Have you ever sprained/strained a joint, torn a ligament, or broken a bone in a way that altered your function ?

❑ Never

❑ A single time_____

❑ Multiple times_____

_____

Have you experiance any other significant injuries ?

❑ Never

❑ A single time _____

❑ Miltiple times_____

_____

Have you had any surgeries?

❑ Never

❑ A single time _____

❑ Multiple times_____

_____

Do you have pain anywhere in your body ?

❑ I'm fully at ease

❑ I have a few minor aches_____

❑ I have regions of minor pain or some regions of moderate to severe pain

_____

_____

Do you have any structural abnormality such as scoliosis, artritis in a joint, different lengths of limbs, or shoulder higher than the other?

❑ No

❑ A minor one that doesn't affect my life _____

❑ Yes, a significant one _____

_____

Do you have any of the following conditions: fibromyalgia, an inflammatory disease, temporomandibular joint disorder (tmj), diabetes or prediabetes, or migraines?

❑ No

❑ No, but it runs in my family_____

❑ Yes _____

_____

How is your range of motion?

❑ I move with ease

❑ I have no major restrictions, but I could be more flexible _____

❑ I have a restricted range of motion(with or without pain) and it significantly interferes with my everyday activities.

_____

Do you experiance urinary leakage when you cough, sneeze, laugh, or exercise?

❑ No

❑ No, but this was a past concern/is likely to become a future concern

❑ Yes _____

Have you experienced emotional trauma or stress for a significant part of your life?

❑ Little to no stress

❑ Moderate stress_____

❑ Significant stress _____

_____

How is your blood pressure?

❑ Within normal range _____

❑ Slightly out of normal range, but managed without medication _____

❑ High _____

How much sleep do you usually get each night?

❑ More than seven hours

❑ Less than seven hours._____

Desired Outcomes from This Session:

_____

*** BFM therapists do not diagnose conditions nor do they prescribe medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. As a holistic healing BFM does not take the place of medical care.**

*** It is recomended to see a licensed physician or licensed health care professional or psychological ailment you may have.**

I understand this session is therapeutic and somatic-based (not a substitute for medical treatment) and consent to receive fascia-focused bodywork from Janna Risch at Synergy Sessions.

Signature: _____ Date: _____