Erika Lutwin, BS, LMT

Client History Intake Form

Name _____ Date of first visit _____

Address _____

Home Phone # _____ Cell Phone # _____

Occupation _____ Date of birth _____

Email Address _____

Physical Activities/Sports/Hobbies _____

Have you had a professional massage before? ☐ Yes ☐ No

Do you have any difficulty lying on your front, back, or side? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any allergies to lotions or other substances on your skin? ☐ Yes ☐ No

If yes, please list: _____

Do you wear contact lenses ◯, dentures ◯, or a hearing aid ◯ ?

Do you sit for long hours at a workstation/computer, or driving? ☐ Yes ☐ No

Do you perform any repetitive movements at your work, sports or hobby? ☐ Yes ☐ No

If yes, please list: _____

Do you experience stress in your work, family or other aspect of your life? ☐ Yes ☐ No If yes, how do you think it has affected your health? Muscle tension ◯ Anxiety ◯ Insomnia ◯ Irritability ◯

Other _____

Is there a particular area of the body where you are experiencing pain, tension or another discomfort?

If yes, please identify: _____

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Are you currently under medical supervision? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Please list any surgeries or serious hospitalization visits including dates:

Description	Date

Have you ever been involved in any accidents? ☐ Yes ☐ No

If yes, please describe and include dates:

Please list the name of your current doctor/health care provider and include their phone number.

_____

For women, are you pregnant? ☐ Yes ☐ No If yes, how many months and are you experiencing any difficulties?

If yes, please describe:

Please check any of the following conditions that you have had or are currently experiencing:

Skin

- ☐ Fungal Infections
- ☐ Herpes simplex
- ☐ Warts
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer

Circulatory

- ☐ Anemia
- ☐ Thrombophlebitis
- ☐ Deep vein thrombosis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Varicose veins
- ☐ Clotting disorders

Digestive

- ☐ GERD (acid reflux)
- ☐ Ulcers
- ☐ Crohn disease
- ☐ Irritable bowel syn.
- ☐ Gallstones
- ☐ Hepatitis

Musculoskeletal

- ☐ Fibromyalgia
- ☐ Rhuematoid arthritis
- ☐ Osteoarthritis
- ☐ TMJ dysfunction
- ☐ Thoracic Outlet Synd.
- ☐ Carpal Tunnel Synd.
- ☐ Strains, sprains, tendonitis
- ☐ Screws, pins, staples

Lymph/Immune

- ☐ Edema
- ☐ Leukemia/lymphoma
- ☐ HIV/AIDS
- ☐ Chronic fatigue syndrome
- ☐ Lupus
- ☐ Any autoimmune disorders

Endocrine

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Urinary

- ☐ Kidney stones
- ☐ Kidney disease

Nervous

- ☐ Depression
- ☐ Multiple sclerosis
- ☐ Post polio syndrome
- ☐ Cysts
- ☐ Headaches/migraines
- ☐ Stroke
- ☐ Seizure disorders
- ☐ Reduced sensation
- ☐ Sleep disorders

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Tuberculosis

Reproductive

- ☐ Breast cancer
- ☐ Endometriosis
- ☐ Ovarian cancer
- ☐ Prostate cancer
- ☐ Painful or Irregular Menstruation

Please list any other current conditions that you may have had or are currently experiencing:

I understand that I should see a doctor or other appropriate health providers for diagnosis and treatment of any suspected medical problem. It may be beneficial for my massage practitioner to speak to my doctor about my medical condition to determine how massage may help the healing process, and to avoid worsening the condition. I will be asked permission to contact my doctor, if the massage practitioner thinks that it might be useful. I also understand that it is my responsibility to keep my massage practitioner informed of any changes in my health, and any medications that I may begin to take in the future.

Signature _____ Date _____

Email Form Print Form