LIFT Total Wellness

Confidential Client Health Intake

Today's Date ____/_____/_____

First:_____ **Middle:**_____ **Last:** _____ **Sex: Male / Female**

Address: _____**Apt #** _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone:**_____ **Cell Phone:** _____ **Birth Date:** _____

Age:_____ **Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** **Occupation:**_____

Employer:_____ **Spouse's Name:**_____ **Spouse's Birthday:** _____

Anniversary:_____ **Email: (internal use only):**_____**Referred by**_____

How would you like to be addressed? First name /Mr. /Mrs./ Ms. **Newsletter:** ☐**yes** ☐**no** **Do you text:** ☐**yes** ☐**no**

Children (Names and Ages): _____

Emergency contact: _____ **Phone Number:** (_____)_____-_____

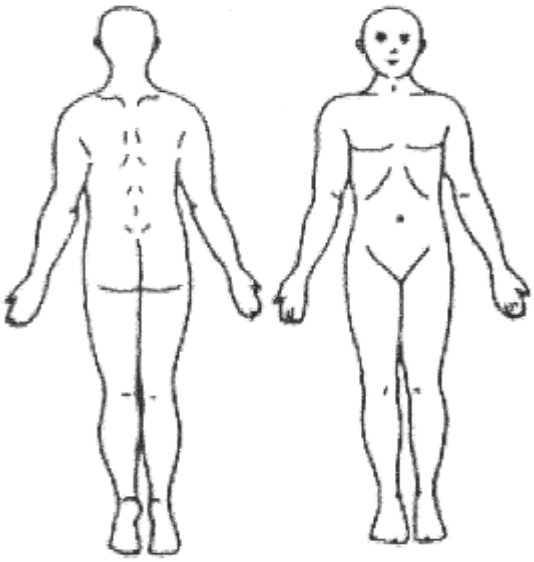
Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

When was your last massage/ pilates session and how often? _____

What are your goals/reasons for coming today? _____
When did this condition begin and has it ever occurred before?_____
How did this condition happen? Please describe._____
Have you seen a doctor for this condition? If yes, who?_____
The following is for massage clients:

Medication	Dosage	For What Condition	How long?

PLEASE LABEL ON THE DIAGRAM THE AREAS OF DISCOMFORT and use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

Appointments may be scheduled in person, phone or via text ONLY. In order to experience your full appointment time, please arrive 5-10 minutes prior to your scheduled appointment. You are responsible for your scheduled appointment, although we do try to offer a courtesy reminder call/text, I reserve an appointment time just for you. A 24-hour notice is required to cancel appointments, so that we may provide pain relief to another or allow another to receive Pilates.. Appointments canceled with less than a 24-hour notice will be charged a cancellation fee equal to that of the entire scheduled appointment time. Acceptable forms of payment are; cash, check, Visa or Mastercard. Please be advised that there is a 20% charge on all returned checks. Prices are subject to change without notice. We are not responsible for lost or stolen items.

I understand that massage therapists and Pilates Instructors do not diagnose illness, disease or any physical or mental disorder. These services are in no way intended to be a substitute for professional healthcare, but used in conjunction with professional healthcare. I have stated all medical conditions of which I am aware, and I will update the therapist/instructor of any change in my health status. All documents and conversations are highly confidential and will not be disclosed with out my written consent. We abide by all HIPAA standards.

****I understand, have read and agree to abide by the cancellation policy.****

_____ _____
Client Signature **Date**

_____ _____
Therapist/Instructors Signature **Date**

Check the following conditions that apply to you, past and present, circling those that have been present in the last month. Please add your comments to clarify the condition.

Musculo-Skeletal

- ☐ **Headaches**
- ☐ **Joint/stiffness/swelling**
- ☐ **Spasms/cramps**
- ☐ **Broken/fractured bones**
- ☐ **Strains/Sprains**
- ☐ **Back/hip pain**
- ☐ **Shoulder, neck, arm, hand pain**
- ☐ **Leg, foot pain**
- ☐ **Chest, ribs, abdominal pain**
- ☐ **Problems walking**
- ☐ **Jaw pain/TMJ**
- ☐ **Tendonitis**
- ☐ **Bursitis**
- ☐ **Arthritis**
- ☐ **Osteoporosis**
- ☐ **Scoliosis**
- ☐ **Bone or joint disease**
- ☐ **Other:_____**

Circulatory & Respiratory

- ☐ **Dizziness**
- ☐ **Shortness of breath**
- ☐ **Fainting**
- ☐ **Cold feet or hands**
- ☐ **Cold Sweats**
- ☐ **Swollen ankles**
- ☐ **Varicose Veins**
- ☐ **Blood Clots**
- ☐ **Stroke**
- ☐ **Heart condition**
- ☐ **Lymphedema**
- ☐ **Sinus problems**
- ☐ **Asthma**
- ☐ **High Blood Pressure**
- ☐ **Low Blood Pressure**
- ☐ **Allergies _____**
  - ☐ **Environmental/food intolerances products/other_____**
- ☐ **Other:_____**

Skin

- ☐ **Rashes/Hives**
- ☐ **Allergies_____**
- ☐ **Athlete's Foot**
- ☐ **Plantar Warts**
- ☐ **Poison Ivy**
- ☐ **Eczema**
- ☐ **Cosmetic surgery**
- ☐ **Other:_____**

Digestive

- ☐ **Nervous stomach**
- ☐ **Indigestion**
- ☐ **Constipation**
- ☐ **Intestinal gas/bloating**
- ☐ **Diarrhea**
- ☐ **Diverticulitis**
- ☐ **Irritable Bowel syndrome**
- ☐ **Crohn's Disease**
- ☐ **Colitis**
- ☐ **Other**

Nervous System

- ☐ **Numbness/tingling**
- ☐ **Twitching of face**
- ☐ **Fatigue**
- ☐ **Chronic Pain**
- ☐ **Sleep Disorders**
- ☐ **Ulcers**
- ☐ **Paralysis**
- ☐ **Herpes/Shingles**
- ☐ **Epilepsy**
- ☐ **Chronic Fatigue Syndrome**
- ☐ **Fibromyalgia**
- ☐ **Multiple Sclerosis**
- ☐ **Muscular Dystrophy**
- ☐ **Parkinson's disease**
- ☐ **Spinal cord injury**
- ☐ **Other:_____**

Reproductive System

- ☐ **Pregnancy:**
  - ☐ **Current** ☐ **Previous**
- ☐ **Yeast Infections**
- ☐ **Menopause**
- ☐ **Pelvic Inflammatory Disease**
- ☐ **Endometriosis** ☐ **PMS**
- ☐ **Hysterectomy**
- ☐ **Fertility concerns**
- ☐ **Prostrate Problems**

Other

- ☐ **Loss of appetite**
- ☐ **Forgetfulness**
- ☐ **Confusion**
- ☐ **Depression**
- ☐ **Difficulty concentrating**
- ☐ **Drug (frequency)_____**
- ☐ **Alcohol (frequency)_____**
- ☐ **Nicotine (frequency)_____**
- ☐ **Caffeine (frequency)_____**
- ☐ **Hearing impaired**
- ☐ **Visually impaired**
- ☐ **Burning upon urination**
- ☐ **Bladder infection**
- ☐ **Diabetes**
- ☐ **Cancer/tumors**
- ☐ **Infectious disease (please list)**
  _____
- ☐ **HIV**
- ☐ **Surgeries (please list)**
  _____
  _____
  _____
- ☐**Other injuries/car accidents in past 5 years_____**
  _____
- ☐ **Under the care of an MD/other healthcare provider (please explain)**
  _____

Please list any additional comments regarding your health and well-being: _____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status. I understand that this health care provider has to abide by all HIPAA standards.

Clients signature: _____ Date: _____