bodymind thai massage

client intake

Client Contact:

Name: _____ Date of birth: _____

Cell phone:_____ Work:_____ Home: _____

Email address:_____

Mailing Address: _____

City/Town:_____ Zip:_____

Lifestyle Profile:

Occupation:_____

Rate your everyday level of stress/over-stimulation (0 – 10, 10 being most stressful) _____

Posture assumed during most of the day: _____

Please describe your diet: (approx.)

Veggies/Fruit _____% Chicken_____% Fish_____ % Bread, Cereals, Rice, Pasta_____%

Meat (Beef, Pork, etc) _____ % Dairy_____ % Processed sugar _____ %

Approximate amount of water intake in a day: _____

Please indicate the approximate frequency of the following (i.e. 1x per week, 10x per day, etc)

caffeine:_____ nicotine: _____alcohol: _____ rec. drugs: _____

Please describe your exercise habits: _____

_____

What do you do to relax?:_____

_____

Describe the quality of your sleep: _____

_____

Your current state of health:

What is your primary complaint(s) or symptom(s)? _____

_____

_____

What are your secondary complaint(s) or symptom(s)? _____

_____

_____

What is the history of these complaints?: (how long, what treatment gives relief, what doesn't?)

_____

_____

_____

Are you presently under a physicians care? _____

Are you presently taking medication?: Yes No (circle one)

If yes, please list medications: _____

If yes, for what reason?: _____

Do you have, or have you had any of the following (check all that apply):

◊ high blood pressure	◊ low blood pressure	◊ high cholesterol
◊ heart/circulatory disease	◊ organ disease	◊ chronic indigestion
◊ peptic ulcer	◊ chronic constipation	◊ irritable bowel
◊ high stress	◊ nervousness/anxiety	◊ diabetes
◊ frequent headaches	◊ fatigue/weakness	◊ hormone imbalance
◊ irregular menstruation	◊ cancer	◊ other: _____
◊ Broken bones	◊ Torn Ligaments	◊ Joint Dislocation

If you have a history of health problems of any kind, please elaborate: _____

_____

Are you now or have you ever been pregnant? _____

Any Surgeries in the last 3 years?: _____

_____

Please include any additional information you feel would be helpful:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Your Doctors Name Telephone Number

By signing below, you acknowledge that the information contained in this form is true to the best of your understanding; that you don't mind us contacting your physician if necessary, and that you understand that this information is confidential and will not be used or discussed for any reason.

_____ _____

Your Signature Date