

# 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)? \_\_\_\_\_

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What are your secondary complaint(s) or symptom(s)? \_\_\_\_\_

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

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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):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> high blood pressure       | <input type="checkbox"/> low blood pressure   | <input type="checkbox"/> high cholesterol    |
| <input type="checkbox"/> heart/circulatory disease | <input type="checkbox"/> organ disease        | <input type="checkbox"/> chronic indigestion |
| <input type="checkbox"/> peptic ulcer              | <input type="checkbox"/> chronic constipation | <input type="checkbox"/> irritable bowel     |
| <input type="checkbox"/> high stress               | <input type="checkbox"/> nervousness/anxiety  | <input type="checkbox"/> diabetes            |
| <input type="checkbox"/> frequent headaches        | <input type="checkbox"/> fatigue/weakness     | <input type="checkbox"/> hormone imbalance   |
| <input type="checkbox"/> irregular menstruation    | <input type="checkbox"/> cancer               | <input type="checkbox"/> other: _____        |
| <input type="checkbox"/> Broken bones              | <input type="checkbox"/> Torn Ligaments       | <input type="checkbox"/> Joint Dislocation   |

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

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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