Larry Dupuis LMT Client Intake Form

Client Name: **Date Completed/Updated:**
Year of birth:

Cell Phone Number: **Alternate Phone:**

Email Address:

Home Address:

In Case Emergency Contact: Phone Number:
Did someone refer you?

(Use back if additional space is needed for any question)

Have you had a professional massage before? Yes □ No □
If yes, please indicate type(s) and frequency

Work and Activity

Why is this information needed: Your most routine activities have the greatest potential opportunity to impact your physical condition. Understanding your activity levels and the nature of that activity helps your therapist understand what type of massage therapy is appropriate and where to be particularly attentive for potential congestion or tension. It also helps your therapists work with you in assessing how your activity(ies) might be adjusted to prevent or limit impacts on your physical being, or alternatively, define activities you can insert to help counter the impacts of required activities.

Occupation Years

Average Hours per day at: Computer: Desk: Video Games: TXTing TV

Sitting: Standing:

Describe any poor ergonomics and/or posture during above activities (e.g. Computer screen low or keyboard high, slouching, sitting for long periods without moving)

Describe any frequent and repetitive movements in your work, sports, hobbies or living? (e.g. TXTing, Gaming, computer use, lifting heavy objects, carrying a bookbag or purse, pushing or pulling objects, routine caregiving, painting, surgery, cleaning, etc.)

Provide overview of routine activities. .. exercise, sports, physical work, dancing, walking, care giving, stair climbing, active play with children, whatever gets you physically engaged:

Describe your sleep positions/habits: (e.g. Sleep on back, stomach, left or right side, fetal position, toes pointed, teeth clenching/grinding, alone or/with people pets, average hours per night, insomnia, RLS, frequent tossing and turning, etc.

Medical History

Why is this information needed: Your current and prior medical conditions, injuries, medications, accidents, etc also have had an opportunity to impact your physical being and may contraindicate some or all massage therapy. In order to manage your session appropriate your health status, your therapists must be informed of all relevant history. It does not matter if you were treated for it or not. If something caused significant or long lasting discomfort, ache or pain or has reduced range of motion it should be reported.

Do you bruise easily? Are you on a blood thinner?

Do you wear: Contact Lenses ☐ Dentures ☐ Hearing Aid ☐ Hair Piece/extensions ☐

Are you currently under medical supervision?

If yes, please explain why and provide frequency of visits and testing that is routinely done.

Do you see any complementary healthcare providers such as a chiropractor or acupuncturist? If yes, what type(s) and how often?

Medication(s): Provide name of medications and purpose for each.

List any vitamins or supplements, energy boosters, etc you are taking.

Do you have any chronic and/or infectious conditions (e.g. diabetes, arthritis, HIV, fibromyalgia, MLS, musculardystrophy, scoliosis, chrones disease, etc)

In the past, have you had any injuries, accidents, collisions, falls or surgeries, especially involving bone, muscle, tendons or ligaments? If yes, please describe and give approximate date:

List any allergies you may have:

Could you currently be pregnant? Yes □ No □

Do you have any difficulty lying on your front, back, or side, or turning over?

If yes, please explain

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

Professional Draping will be used throughout the session – only the area of your body being worked on will be uncovered.

I, (print name) _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort or am otherwise uncomfortable or concerned during any session, I will immediately inform the therapist so that adjustments can be made to bring it into line with my levels for comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated regarding any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

All information provided on this form as well as the details of your session will be held in strict confidentiality and will never be shared without your prior consent unless ordered to do so by court of law or authorized government official..

Signature of Client _____ Date_____