Lotus Awakening Bodywork

Client Intake Form

NAME:	DATE OF BIRTH:
ADDRESS:	
CITY:	STATE/ZIP CODE:
BEST CONTACT PHONE #:	EMAIL:

Have you received massage therapy before? ☐ YES ☐ NO

Are you currently taking any medications that may be affected by massage? If so, please list below:

____

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Are you currently seeing a healthcare professional? ☐ YES ☐ NO If yes, please list names and reason/treatment:

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Please review this list and check those conditions that have affected your health either recently or in the past. Check the box next to the condition.

☐ Arthritis
☐ Broken bones/dislocation
☐ Cancer
☐ Constipation/diarrhea
☐ Diverticulitis
☐ Heart conditions
☐ Muscle strain/sprain
☐ Scoliosis
☐ TMJ Disorder

☐ Autoimmune condition*
☐ Bruise easily
☐ Chemical dependency(alcohol,drugs)
☐ Depression, panic disorder, etc..
☐ Hepatitis(A,B,C, Other)
☐ High blood pressure
☐ Pregnancy
☐ Skin conditions (Contagious? Y / N)
☐ Whiplash

☐ Blood clots
☐ Back problems
☐ Chronic pain
☐ Diabetes
☐ Headaches
☐ Insomnia
☐ Seizures
☐ Surgery
☐ Other

*(AIDS, Fibromyalgia, Chronic fatigue, Lupus, etc…)

If any of the above needs to be detailed or if there is anything else to share, please do so:

____

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Do you have any of the following today:

☐ Skin Rash ☐ Cold/Flu ☐ Open Cuts ☐ Severe Pain
☐ Injuries/Bruises ☐ Anything Contagious

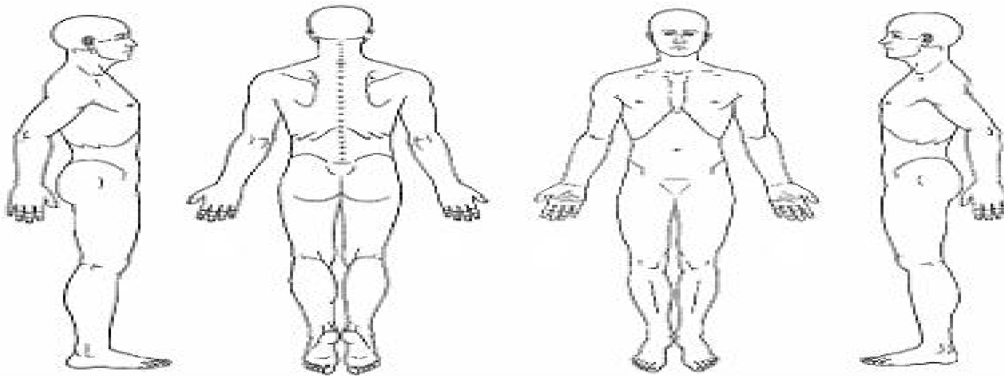
Do you have any allergies to:

☐ Environmental allergens(dust, pollen, fragrances etc...) ☐ Reactions to skin care products
☐ Foods(nuts, etc..)

If any of the above are checked, please give details:

Are you wearing: ☐ contact lenses ☐ hearing aid ☐ hair piece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session?

COVID-19 Related Questions

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?
Yes ☐ No ☐
3. Do you now, or have you recently had, any chills, muscle aches, new loss of taste or smell, or new rashes or
lesions? Yes ☐ No ☐
4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐