Back to Self Bodywork
Health History Intake Form

Name _____ Phone _____ Today's Date_____

Address _____ City/State/Zip _____ AGE _____

Occupation _____Email_____

Primary Physician _____ Emergency Contact _____

Relationship _____ Phone (c)_____ DOB_____

How did you hear about us?_____

---

*Have you had a professional massage before? ☐ yes ☐ no

*What type of service are you seeking?

☐ Bowenwork ☐ Scar Tissue Release ☐ Lymph Drainage

*Do you have any allergies or sensitivities to essential oils or lotions? ☐ yes ☐ no

*Please explain_____

Please check all that apply:

__Abdominal/digestive problem
__Allergies/hay fever
__Arthritis – (location):
_____
__Asthma
__Ankle problem
__Back pain -(location):
_____
__Bed wetting (children)
__Bone spurs
__Breast lump
__Breast pain
__Breast implants
__Bronchitis
__Bunion
__Bursitis
__Buttock pain
__Cancer
__Carpal tunnel syndrome

__Chest pain
__Colic (baby)
__Constipation
__Diabetes
__Diaphragm pain/tightness
__Diarrhea
__Dizziness
__Ear or eye problem
__Edema, general
__Elbow pain, tennis or golf
__Fatigue, chronic
__Fibromyalgia/polymyalgia
__Fibroids
__Fracture -(location)
_____
__Fallen on tailbone/coccyx
__Gall bladder problem
__Heating pad/ice pack usage
__Heating/cooling salve usage
__Hammer toes

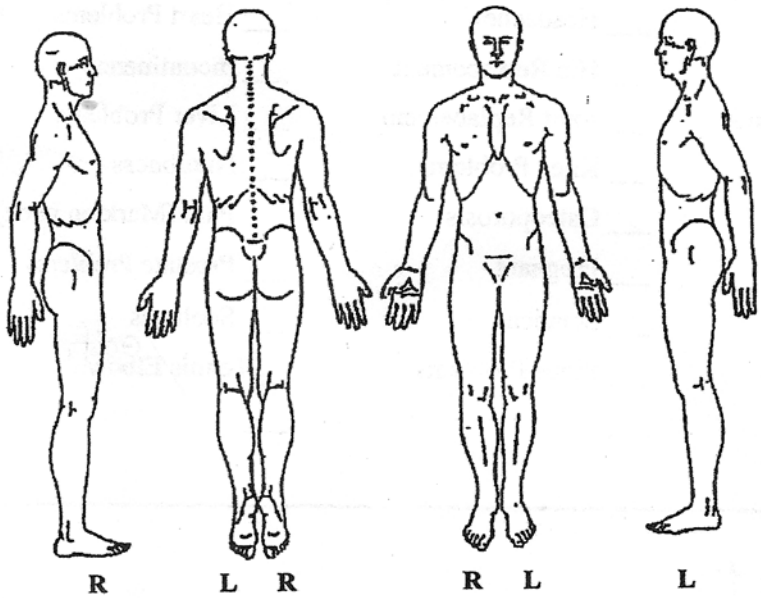
__Hamstring pain/tightness
__Headaches
__Heart problem
__Hernia
__Hip pain
__Hip replacement
__Incontinence / bladder
__Infertility
__Jaw / TMJ problem
__Joint replacement-
_____
__Knee problem
__Liver Problem
__Lung Problem
__Migraines
__Numbness -(location):
_____
__Orthodontia, extensive
__ Orthotics in shoes
__Osteoporosis

__Pain, other -(location):
_____
__Pelvic pain
__Plantar fasciitis/neuroma
__PMS/menopause
__Pregnancy
__Rib pain/subluxation
__Sacral pain
__Sciatica
__Scoliosis
__Shin splints
__Shoulder problem
__Sleep/energy problem
__Tinnitus
__Uterine/ovary problem
__Wrist/thumb pain
__ Scars- (location):
_____
_____
_____

Are you currently taking any medication? ☐ yes ☐ no
If yes, please list:
_____

_____

Please mark where you feel pain or discomfort



Neck ROM:
L

R

TMJ:

Shoulder ROM:

L

R

Pain intensity scale – choose one
(2) Mild pain (annoying, nagging)
(4) Discomforting (troublesome, numbing)
(6) Distressing (miserable, agonizing, gnawing)
(8) Intense (cramping, dreadful, horrible)
(10) Excruciating (tearing, crushing, unbearable)

Recent hands-on modalities received: _____
I have stated, to the best of my knowledge, my known medical conditions. I understand that Bodywork is given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from stiffness. I understand that the therapist does not diagnose illness or disease, nor treat specific physical or mental disorders. I will inform my therapist of any changes in my condition, and will contact my therapist should I have any concerns. I, the client, or the massage therapist may discontinue the treatment at any time for any reason. I am aware this is a non-sexual massage. Lastly, I hereby waive and release Caran Johnson LMT from all liability, past, present and future, relating to lymphatic draining massage, scar tissue release and Bowenwork [including COVID-19_____{initial & date}].

I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED AND AGREE TO PAY ALL FEES NOT REIMBURSED BY INSURANCE COVERAGE INCLUDING, BUT NOT LIMITED, TO LATE FEES, BILLING CHARGES, AND COLLECTION FEES IF WARRANTED.

Client Signature_____Date_____

Therapist Signature _____Date _____