Client Intake Form

Name _____ **Birthdate: D/M/Y** _____

Address _____

City _____ **Postal** _____

Phone _____ **Cell** _____

Email _____

Have you had a massage before?	Yes	No
Do you have any allergies to Oils/Lotions/Flowers/Plants _____	Yes	No
Have you ever had a major accident? _____	Yes	No
Do you sit for long hours at a workstation/computer or while driving?	Yes	No
Do you experience stress in your work, family or other aspect of your life?	Yes	No
Are you presently taking any medication and/or vitamin supplements?	Yes	No

If so, which? _____

Sleep Patterns

What time do you go to sleep / wake up? _____ / _____

How long does it take for you to fall asleep? _____

How many times do you wake in the night? At what hour(s)? _____

_____

Rate the amount of stress from 1 (low) to 10 (high):

Physical _____

☐ Back Pain: Low Mid Upper (Circle) ☐ Neck Pain ☐ Muscle Weakness ☐ Sore/Achy ☐ Other?

_____

Mental _____

☐ High Work Stress ☐ Too many hours ☐ Lots of Travel ☐ Daycare Issues ☐ Other?

_____

Emotional _____

☐ Anxiety/Depression ☐ Grief ☐ Overwhelm ☐ Sudden Weight loss/gain ☐ Other?

_____

Medical History

Please check off any conditions that apply to you:

☐ Contagious skin condition	☐ Open sores or wounds	☐ Chronic Fatigue
☐ Depression/Anxiety	☐ Arthritis	☐ Fibromyalgia
☐ Allergies/Sensitivity	☐ Bruise Easily	☐ Diabetes
☐ Headaches/Migraines	☐ Cancer	☐ Heart Disease
☐ Carpal Tunnel Syndrome	☐ Ulcers	☐ TMJ
☐ Low/High Blood Pressure	☐ Kidney Stones	☐ Hernia/ Sciatica
☐ Varicose Veins	☐ Epilepsy	☐ Sensitive skin
☐ Currently Menstruating	☐ Cysts/Blood Clots	☐ Nausea

☐ Infectious conditions e.g. Athlete's Foot, Cold Sores

☐ Joint/Spinal Issues e.g. degenerated discs, stiffness, or dislocations _____

☐ Pregnancy – How far along _____ ☐ Breastfeeding

What depth would you like for this treatment: Light ☐ Medium ☐ Deep ☐ Not sure ☐

How did you hear about Oceana Massage? If online, which website? _____

Do you have any goals or intentions for this session? i.e. Relaxation, Sleep, Pain relief, Stress Management, etc

_____

_____

Is there any other information you feel would benefit this treatment?

_____

_____

_____

_____

All client information is kept **strictly confidential** according to Provincial Privacy Laws. By giving your email address you are consenting to receive information from Oceana Massage **only**. Holistic healing bodywork treatments are beneficial to your body and mind; they are meant to work with medical intervention and not as a medical replacement. Please see your doctor if you have any concerns or contraindications. All treatments are by personal choice and are at your own discretion and risk. **Oceana Massage** is not responsible for any and all possessions. **Cancellation policy:** You will be charged the full cost of any missed appointments when cancelling within 24 hours.

Today's treatment _____

_____ Date _____

Signature