Monica Valenti
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Relax Renew Reimagine

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INTAKE FORM

I appreciate your taking the time to answer these questions. It provides important background information that helps me tailor effective sessions to meet your particular needs and saves time at our initial meeting. I will always respect your privacy and assure you this information will be kept absolutely confidential.

Please fill out and return this form at least 24 hours before your session. Email or mail it back to me when completed. I will have you sign the consent segment of the form in my office at our first meeting.

Name _____

Address _____

City/State/Zip code _____

Home Phone _____ Work Phone _____

Mobile phone _____

Email _____

Occupation _____

Date of Birth _____

Referred by _____

Physician Name _____

Physician Phone _____

MASSAGE INFORMATION:

Have you received professional bodywork/massage before?

If yes, what type? (Swedish, Shiatsu, deep tissue, etc.)

What kind of pressure do you prefer? (light, medium, firm)

What are your goals for treatment?

What are your current symptoms/issues?

stress pain stiffness

numbness other:_____

Do your symptoms interfere with these activities of daily living?

sleep exercise work

school other: _____

If yes, please explain: _____

CURRENT HEALTH:

How have you been feeling lately? _____

Exercise or any activity you do regularly? If yes, what exercise/activity?_____

Perform any repetitive movement in your work, sports, or hobby? If yes, please describe. _____

Sit for long hours driving or at work?

Recently sustained an injury, had surgery, or have area(s) of inflammation? If yes, please describe.

Have any allergies? If yes, please explain.

Wear contact lenses?

Wear hearing aids?

Wear dentures?

Wear a hairpiece?

Smoke? If yes, how many years?_____

How many cigarettes do you smoke daily?_____

SLEEP:

How is your sleep pattern?_____

What position do you sleep in?_____

Do you feel rested when you wake up?_____

Do you have insomnia?_____ If yes, is it

Occasional? Chronic?

Is there a pattern?_____

Health History:

Circle "P" to indicate you have had this condition in the past.

Circle "C" if the condition is current. If the current, please indicate the date of onset. If the cause was an injury, indicate the details.

MUSCULO-SKELETAL

Muscle/joint stiffness? P C _____

Muscle/joint pain? P C _____

Cramping? P C _____

Broken bones? P C _____

Tendonitis? P C _____

Rheumatoid arthritis? P C Joints affected?_____

Osteoarthritis? Joints affected? P C _____

Bursitis? Joints affected? P C _____

Jaw pain or TMJ. Side affected? P C _____

Spinal problems/scoliosis? P C _____

Osteoporosis. Area affected? P C _____

HEADACHES

Headaches P C _____

Occasional? Pattern? P C _____

_____

Chronic? Pattern? P C _____

Part of head affected? P C _____

MIGRAINES

Occasional? Pattern? P C _____

_____

Chronic? Pattern? P C _____

Which part of head affected? P C _____

CIRCULATORY

Heart condition? P C Details:_____

Phlebitis/varicose veins? P C _____

Blood clots/embolism? P C _____

High blood pressure? P C _____

Low blood pressure? P C _____

Lymphedema? P C _____

RESPIRATORY

Shortness of breath/asthma? P C _____

Occasional? Chronic?

Sinus problems? P C _____

NERVOUS SYSTEM

Tingling/numbness? P C Where? _____

Sensitivity to touch? P C Where?_____

Chronic pain? P C Where? _____

Shingles? P C When?_____Where?_____

Parkinson's Disease? Date of onset?_____
Where symptomatic? _____

Multiple Sclerosis? P C Date of onset? _____
Where symptomatic? _____

DIGESTIVE

Gas/bloating? P C When? _____

Bladder/kidney problem? P C _____

Colitis? P C _____

Irritable Bowel/Crohn's disease? P C _____

Ulcer? P C _____

Hernia? P C _____

SKIN

Bruise easily? P C _____

Allergies? To which foods/substances? P C _____

Rashes? P C _____

Cosmetic surgery? P C Part of body?_____

Cold sores? P C _____

Athlete's foot? P C _____

PSYCHOLOGICAL

Memory loss/confusion? P C _____

Anxiety/Stress? P C _____

Depression? ? P C Are you on medication?_____

If so, which ones? _____

OTHER

Dizziness? P C _____

Restless leg syndrome? P C _____

Endocrine/thyroid condition? P C _____

Cancer? P C _____

Diabetes? P C _____

Tinnitus? P C _____

Past surgeries? Details: _____

_____

_____

_____

Any other medical condition(s) _____

_____

_____

_____

Medications? Please list all medications you are currently taking.

_____

_____

_____

Is there anything else you would like me to know? _____

_____

_____

_____

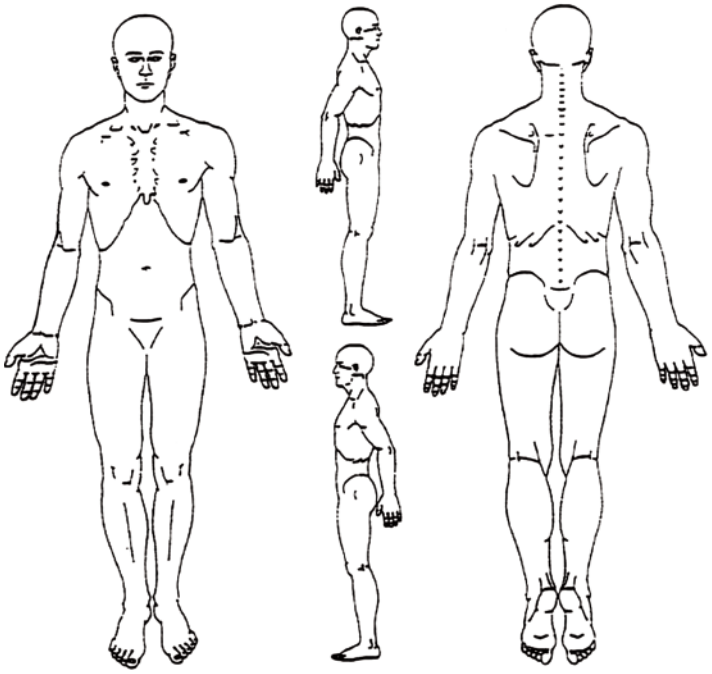
_____

_____

_____

_____

Please circle the location(s) where you currently have pain or discomfort:



CLIENT CONSENT

I understand that the massage given to me by Monica Valenti is for the purpose of stress reduction, pain reduction, relief from muscle tension and increasing circulation.

I understand that Monica Valenti does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver or a medical specialist for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep Monica Valenti updated on any changes.

_____

Client Name

_____

Client/Guardian Signature

_____

Date