Client Initial Intake Form

Name: _____ Date of Birth:_____
Address:_____ Phone Number: _____

_____ email: _____

Medical History:

List all current and previous orthopedic injuries: _____
_____
_____
_____

- ☐ heart disease
- ☐ high blood pressure
- ☐ malignancy
- ☐ auto immune disorder
  Please list:_____
- ☐ mental illness
  Please list: _____
- ☐ DVT
- ☐ Hemmorage
- ☐ Stomach ulcers
- ☐ Diabetes
- ☐ Fractures
  Please list: _____
- ☐ Stroke
- ☐ TBI
- ☐ Chronic Fatigue Disorder
- ☐ Cancer

Type:_____

Location:_____

- ☐ Cerebral palsy
- ☐ Parkinson's disease
- ☐ Multiple sclerosis
- ☐ Peripheral neuropathy
- ☐ Vascular disease
- ☐ Insomnia
- ☐ Depression
- ☐ Headaches
- ☐ Migraines
- ☐ Thyroid imbalances
- ☐ Metabolic disorders
- ☐ Hormonal irregularities
  Please list:_____
- ☐ Other:_____

_____
_____

Allergies: _____
Medications:_____
Are you a current or previous smoker? _____

Orthopedic:

Please list all previous injuries/accidents that have occurred: _____

_____
_____

Reason for therapy/what do you hope to gain from therapy: _____

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at: Unwind Center
1908 W Koenig Lane
Austin, TX, 78751

_____

_____

Please list all surgeries: _____

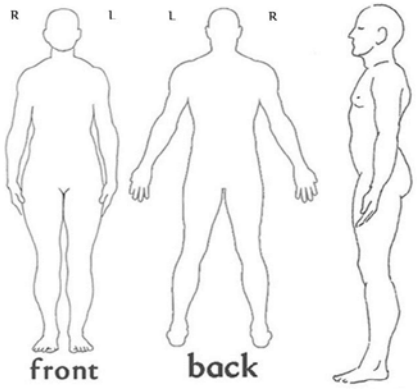
_____

Pleas list areas of the body that are sore/painful; _____

_____

_____

_____



List any other sensations you have been experiencing: _____

_____

Contraindications:

Please check off all contraindications, as they could have negative affects to treatment, if therapist does not know about them:

- ☐ Aneurysm
- ☐ Acute rheumatoid arthritis
- ☐ Celluitis
- ☐ Systemic or local infection
- ☐ DVT
- ☐ Osteomyelitis
- ☐ Obstructive edema
- ☐ Open wounds
- ☐ Sutures
- ☐ Hematoma
- ☐ Fracture
- ☐ Osteoporosis
- ☐ Anticoagulant therapy
- ☐ Advanced diabetes
- ☐ Hypersensitivity to skin
- ☐ Pregnant (or possibility you are pregnant)

Have you received a professional massage before? _____

Are there any areas you are uncomfortable receiving myofascial release? _____

_____

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The massage therapist shall not engage in breast massage of female clients without the written consent of the client. Not all areas of the body will be addressed in one session. Sessions typically include head, neck, chest, stomach, back, pelvis, sacrum, hips, legs, arms, feet and hands. If you are uncomfortable with MFR any of these areas, please inform the therapist. Draping will be used during the session, unless otherwise agreed to by both the client and the licensee. If uncomfortable for any reason, the client may ask the licensee to cease the massage and the licensee will end the massage session.

I, _____, consent to receive massage therapy treatment from Matrix Therapy, LLC. This treatment is a myofascial release treatment. I understand that these techniques will be explained to me beforehand, and I have the right to refuse treatment at any time. I understand that the risk for injury during treatment is low, but temporary soreness is a common side effect for treatment. Massage therapy is not a substitute for a medical exam or diagnosis. You may wish to consult a doctor concerning any possible illness you may have. I understand a Massage Therapist does not diagnose or prescribe medical treatment or pharmaceuticals.

_____

Patient signature

_____

Legal Guardian (if under 18)

_____

Therapist Signature

_____

Date

Acknowledgement of HIPAA Notice

I, _____, acknowledge that I have received the Notice of Privacy Practices from Matrix Therapy, LLC.

_____ _____

Signature Date

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