

# REJUVENATION STATION

## CLIENT INTAKE INFORMATION FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (eve) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Physician: \_\_\_\_\_

Previous experience with massage: \_\_\_\_\_

Primary reason for appointment / areas of pain or tension: \_\_\_\_\_

Emergency Contact - Name and Number: \_\_\_\_\_

**Please mark (X) for all conditions that apply now. Put a (P) for past conditions, an (F) for family history of illness.**

Pain Scale: minor - 1		2	3	4	5	6	7	8	9	severe - 10
_____ headaches, migraines	_____ chronic pain	_____ fatigue								
_____ vision problems, contact lenses	_____ muscle or joint pain	_____ tension, stress								
_____ hearing problems, deafness	_____ muscle, bone injuries	_____ sleep difficulties								
_____ injuries to face or head	_____ numbness or tingling	_____ depression								
_____ sinus problems	_____ sprains, strains	_____ allergies, sensitivities								
_____ dental bridges, braces	_____ arthritis, tendonitis	_____ rashes, athetes foot								
_____ jaw pain, TMJ problems	_____ cancer, tumors	_____ infectious diseases								
_____ asthma or lung conditions	_____ diabetes	_____ blood clots								
_____ constipation, diarrhea	_____ pregnancy	_____ varicose veins								
_____ hernia	_____ heart, circulatory problems, stroke	_____ high/low blood pressure								
_____ birth control, IUD	_____ phobias	_____ cerebral palsy								
_____ abdominal or digestive problems	_____ antibiotics	_____ epilepsy								
_____ hormone therapy	_____ other medical conditions not listed	_____ acne/acutane								
		_____ psoriasis, eczema								

\_\_\_\_\_ vitamins / supplements \_\_\_\_\_ diuretics How much water do you drink daily? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ How would you describe your overall level of stress? \_\_\_ low, \_\_\_ Medium, \_\_\_ high

Explain any areas noted above: \_\_\_\_\_

Current medications, including aspirin, ibuprofen, herbs, supplements, etc.: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Accidents: (Bodily Injury) \_\_\_\_\_

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation: \_\_\_\_\_