Session Goals Intake

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1. Client Information

Please fill this out before every session. You will also receive a follow-up e-mail after your session to give full feedback. Should take about 5-10 minutes depending on your conditions and goals. Thank you for taking the time. This helps me provide you with the most effective treatment and gives you the most time on the table to enjoy the work.

Today's Date:

First Name:

Last Name:

Phone Number:

E-mail Address:

Your Medications Today:

What are your daily activities?

Areas to Avoid Today:

Client Comments:

Pressure Preference:
○ light ○ medium ○ firm ○ combination

You may adjust pressure at any time during the massage simply by letting me know. I will also check in from time to time.

Do you have any difficulty hearing?
○ *yes* ○ *no*

If "yes", please explain:

If "yes", explain here:

Do you have any mobility concerns?
○ *yes* ○ *no*

Do you have any difficulty lying on your back, on your stomach, or on your side?
○ *yes* ○ *no*

Do you have any allergies or sensitivities, especially to lotions, oils, scents, or fabrics?
○ *yes* ○ *no*

If "yes", explain here:

_____

If "other", please explain:

_____

If "yes", explain here:

_____

Are you wearing (check all that apply):
☐ *contact lenses* ☐ *hearing aids* ☐ *dentures*
☐ *hairpiece* ☐ *pacemaker* ☐ *other*

Any recent accidents, injuries, surgeries, or procedures?
○ *yes* ○ *no*

2. Current Conditions & Contagious Illnesses

Should the practitioner or client feel sick or contract a contagious disease that could spread during the massage session, we must reschedule. Please indicate if you are experiencing any of the following conditions or symptoms today or in the past 24 hours. Check all that apply. Note that not all of these are contradictory to massage, some are just important for me to know. I will notify you if we need to reschedule because of something that makes massage therapy inadvisable.

☐ *flu/cold/covid symptoms* ☐ *fever over 100*
☐ *nausea/vomiting* ☐ *headache/migraine*
☐ *coughing with sore throat*
☐ *congestion/runny nose not allergy-related*
☐ *menstruating* ☐ *pregnant* ☐ *depressed/anxious*
☐ *pneumonia* ☐ *open wound* ☐ *bruise* ☐ *rash*
☐ *athlete's foot* ☐ *wart(s)* ☐ *chicken pox/shingles*
☐ *mono* ☐ *herpes outbreak* ☐ *lice*
☐ *heart condition* ☐ *blood clots* ☐ *stroke*
☐ *deep vein thrombosis* ☐ *high blood pressure*
☐ *low blood pressure* ☐ *dizziness/fainting*
☐ *epilepsy/seizures*
☐ *other (please explain in the next box)*

Feel free to elaborate here:

_____

_____

3. Primary Client Concern

What brings you in today? Be as detailed as possible!

Primary Concern:

_____

_____

How long have you had this issue?

_____

Have you tried anything else to manage this issue?

_____

Are you expericing any of the following? Check all that apply.
☐ *muscle/joint pain* ☐ *stiffness* ☐ *muscle spasms* ☐ *decreased mobility* ☐ *swelling/edema* ☐ *numbness*
☐ *loss of function* ☐ *other (explain below)*

If you checked any of the above, please explain:

_____

_____

Describe the level of your discomfort:

○ *0: no discomfort* ○ *1-2: somewhat noticeable discomfort* ○ *3-4: very noticeable discomfort*
○ *5-6: mildly debilitating* ○ *7-8: moderately debilitating* ○ *9: completely debilitating*
○ *10: excruciating pain*

If you have pain, describe how it feels (check all that apply):

☐ *intermittent* ☐ *constant* ☐ *surface muscular* ☐ *deep muscular* ☐ *mild ache*
☐ *persistent ache/chronic pain* ☐ *emotional* ☐ *sharp* ☐ *burning* ☐ *stabbing* ☐ *shooting* ☐ *tingling*
☐ *other (please describe below)*

Elaborate on your pain:

_____

_____

4. *Secondary Client Concern (optional)*

If you have a secondary concern for treatment today, please detail it here. Feel free to leave this blank if you only want to focus on your primary concern.

Secondary Concern:

_____

_____

How long have you had this issue?

_____

Have you tried anything else to manage this issue?

_____

Do you have any of these concerns? Check all that apply.

☐ *muscle/joint pain* ☐ *stiffness* ☐ *muscle spasms* ☐ *decreased mobility* ☐ *swelling/edema* ☐ *numbness*
☐ *loss of function* ☐ *other (explain below)*

If you checked any of the above, please explain:

_____

_____

Describe the level of your discomfort:

○ *0: no discomfort* ○ *1-2: somewhat noticeable discomfort* ○ *3-4: very noticeable discomfort*
○ *5-6: mildly debilitating* ○ *7-8: moderately debilitating* ○ *9: completely debilitating*
○ *10: excruciating pain*

If you have pain, describe how it feels (check all that apply):

☐ *intermittent* ☐ *constant* ☐ *surface muscular* ☐ *deep muscular* ☐ *mild ache*
☐ *persistent ache/chronic pain* ☐ *emotional* ☐ *sharp* ☐ *burning* ☐ *stabbing* ☐ *shooting* ☐ *tingling*
☐ *other (please describe below)*

Elaborate on your pain:

_____

_____

5. *Tertiary Client Concern (optional)*

If you have a tertiary concern for treatment today, please detail it here. Feel free to leave this blank if you only want to focus on your primary concern.

Tertiary Concern:

How long have you had this issue?

Have you tried anything else to manage this issue?

Do you have any of these concerns? Check all that apply.
☐ *muscle/joint pain* ☐ *stiffness* ☐ *muscle spasms* ☐ *decreased mobility* ☐ *swelling/edema* ☐ *numbness*
☐ *loss of function* ☐ *other (explain below)*

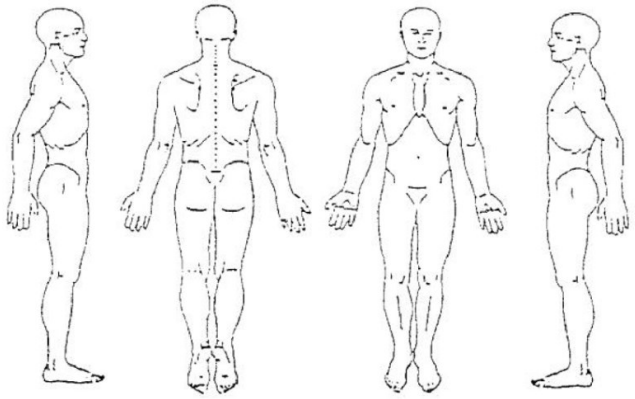
If you checked any of the above, please explain:

Describe the level of your discomfort:
○ *0: no discomfort* ○ *1-2: somewhat noticeable discomfort* ○ *3-4: very noticeable discomfort*
○ *5-6: mildly debilitating* ○ *7-8: moderately debilitating* ○ *9: completely debilitating*
○ *10: excruciating pain*

If you have pain, describe how it feels (check all that apply):
☐ *intermittent* ☐ *constant* ☐ *surface muscular* ☐ *deep muscular* ☐ *mild ache*
☐ *persistent ache/chronic pain* ☐ *emotional* ☐ *sharp* ☐ *burning* ☐ *stabbing* ☐ *shooting* ☐ *tingling*
☐ *other (please describe below)*

Elaborate on your pain:

6. ***Indicate on the chart below the area(s) you would like the therapist to focus on:***



Client Comments:

7. ***Other Concerns***

Signature