Essentials of Trinity **Intake Form**

Name:		Date:	Occupation:
Address:		Phone:	Date of Birth:
City:	State:	Zip Code:	How did you hear about us?
Emergency Contact Name:			Phone:
Email:			Cell Provider:

General Health

1. Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1
2. List your stress or other stress reduction activities:
3. Do you wear contact lenses? ☐ Yes ☐ No
4. Do you smoke? ☐ Yes ☐ No How many cigarettes per day?
5. Please list any accidents or surgeries in the last 9 months:
6. Do you have any metal implants, a pacemaker or body piercings?
7. List the medications you are currently taking:

Massage Therapy	**Goal For Your Massage Session**
Have you ever had a professional massage before? If so, when?	☐ Relaxation
What type of pressure do you prefer?	☐ Pain Relief
Is there any area of your body you do not want massaged?	☐ Stress reduction

Health History

☐Heart Condition	☐Lymph Edema	☐Herpes/Shingles	☐High Blood Pressure	☐Low Blood Pressure
☐Numbness/Tingling	☐Sinus Problems	☐Allergies	☐Chronic Pain	☐Varicose Veins
☐Rashes	☐Jaw Pain/TMJ	☐Blood Clots	☐Constipation	☐Sprains/Strains
☐Diabetes	Gas/Bloating	Headaches	Arthritis	Spasms/Cramps
Broken/Fractured Bones	Pregnancy (___weeks)	Fatigue/Sleep Disorder	Depression/Anxiety	Cancer
Other (explain): ☐ ☐				

Skin Care

1. Are you under the care of a dermatologist? Yes ☐ No ☐
2. Do you use: Accutane ☐ Retin A ☐ Renova ☐ Adapalene ☐ Other prescription skin products
3. Have you had a: Chemical Peel Microdermabrasion Botox Other resurfacing treatments
4. Are you currently using any products that contain: Glycolic Acid Lactic Acid Hydroxy Acid Vitamin A
5. Do you have any skin sensitivities, allergies or irritants?

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it superseded any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation from treatments received. The treatments I receive here are voluntary and I release this institution and individual therapist from any and all liability and assume full responsibility thereof. For minors under the age of 18, parent or guardian signature constitutes consent.

Client or Parent Signed:_____ Date: _____

Privacy Notice: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.