Client Intake Form

Brian Jensen, Ph.D., CMT

Date

Name	DOB	Age
Address		
City	State	Zip
Email	Occupation	
Emergency Contact	Phone	
How did you hear about us?		

Have you ever received Myofacial Release Therapy (MFR)? Yes ☐ No ☐

Type of Bodywork experienced:

☐ Deep Tissue ☐ Swedish ☐ Other

Describe: _____

Are you taking any medication? Yes ☐ No ☐

Describe: _____

Are you pregnant? Yes ☐ No ☐

Have you consumed alcohol in the last 24 hours? Yes ☐ No ☐

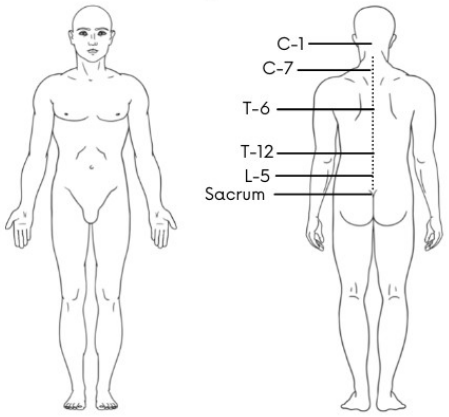
Please indicate your consumption level:

	None	Light	Moderate	Heavy
Salt	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water	☐	☐	☐	☐

Do you have a history of any of the following?

☐ Accident	☐ Sprains	☐ Mastectomy
☐ Neck Pain	☐ Seizure	☐ Breast implants
☐ Whiplash	☐ Abdominal Pain	☐ Diabetes
☐ Headaches	☐ Nervous Tension	☐ Varicose Veins
☐ Shoulder Pain	☐ Arthritis or gout	☐ High Blood Pressure
☐ Upper Back Pain	☐ Allergies to scents	☐ Stroke
☐ Mid Back Pain	☐ Wear Contacts	☐ Heart Attack
☐ Low Back Pain	☐ Scoliosis	☐ Cancer
☐ Joint Ache	☐ Surgery	☐ Colitis
☐ Range of motion	☐ Fibromyalgia	☐ HIV
☐ Broken Bones	☐ Carpal Tunnel	☐ _____

Please indicate with an (X) the areas you are feeling discomfort:



What are your goals for this MFR therapy session?

_____

_____

Do you have any of the following today?

☐ Sunburn	☐ Open cuts, bruises, burns
☐ Severe Pain	☐ Irritated Skin Rash
☐ Inflammation	☐ Poison Ivy
☐ Headache	☐ Cold/Flu

Please read the following and sign below:

- I understand that this Myofacial Release Therapy is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation if less than 24 hours.

Date _____ Signature _____