Orchid
chinese medicine & acupuncture

Massage/Reiki Client Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Are you taking any medication? Yes / No (Please list)

Are you under the care of a medical practitioner? Yes / No

Have you ever had a Massage or Reiki treatment? Yes / No

Do you have a particular area of concern?

Are you sensitive to perfumes or fragrances? Yes / No

Are you sensitive to touch? Yes / No

If you have had any recent or chronic medical conditions, please check them below:

____ Blood Clotting Disorder	____ Recent Surgery	____ Respiratory
____ Circulatory/Heart	____ Herniated Disks	____ Digestive
____ Ulcers	____ Varicose Veins	____ Arthritis
____ Diabetes	____ Anemia	____ Allergies
____ Fractures /Bone Trauma	____ Headaches	____ Nausea
____ Fainting or Dizzy Spells	____ Car Accidents	____ Epilepsy
____ Muscle Cramping	____ Wear Contacts	
____ Allergies to Essences/Oils	____ Jaw Pain or Injury	
____ Neurological Problems	____ Malignant Condition/Cancer	
____ High Blood Pressure	____ Dislocations, Strains, Sprains	
____ TB/Communicable Disease	-____ Back/Neck Discomfort/Injuries	

____ Numbness/Tingling **____ Had Alcohol in the last hour**
____ Plantar Warts **____ Wear Dentures**
____ Skin Conditions/Irritations/Lumps

Are you pregnant? Yes / No If so, how many weeks: _____

If so, Name of OB or Midwife: _____

Any complications or problems we should know about associated with this or a previous pregnancy?

Are you currently or have you undergone chemotherapy or radiation? Yes / No
Have you had lymph nodes removed? Yes / No

Name of Oncologist: _____

Do you have any other medical conditions that your practitioner should know about or be aware of?

Please Read Before Signing:
I understand the purpose of this treatment is for stress reduction, relief from muscular tension, or for increasing circulation. I understand the practitioner does not diagnosis disease, illness or any other physical or mental conditions. As such, the practitioner does not prescribe medical treatment or any pharmaceuticals. This treatment is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical aliment that I have. I understand that practitioners need to be aware of existing physical conditions, therefore, I have stated all of my known medical conditions and take it upon myself to keep the practitioner updated on my physical health.

I also understand that any illicit or sexually suggestive behavior, remarks, or advances made by me will result in immediate termination of the session and I will still be liable for payment of the scheduled session.

Printed Name: _____ Date: _____

Signature: _____