

Wendy Lessard, LMT. 370 Christian Ridge Road, Ellsworth, ME 04605
207.460.4147

Client Intake

Please answer accurately to best & safely meet your needs.

Name: _____ **Date of Birth:**

Mailing Address:

Street or P.O. Box

Town, State

Zip

Email address:

Best Contact Telephone Number(s):

_____ (Home)

_____ (Cell)

Referred by:

Occupation: _____ **Have you received massage before?:** _____

Regular physical activities:

(This can be from weight lifting to walking, hera-bands to cleaning.)

Primary reasons for scheduling a massage. Please describe any pain, limited range of motion, or difficulty with activities:

Any secondary concerns you would like to address in any remaining time? _____

Please list any conditions that are being treated by prescribed medication:

Check if you currently have, or have had within the last year, any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Whiplash (C) | <input type="checkbox"/> Mouth Breather (B) |
| <input type="checkbox"/> Hard body/tail bones hits or falls (C) | <input type="checkbox"/> TMJ (B) |
| <input type="checkbox"/> Migraines/Tension Headaches (C) | <input type="checkbox"/> Teeth Grinding (B) |
| | <input type="checkbox"/> Asthma (B) |
| <input type="checkbox"/> Colitis/IBS (G) | <input type="checkbox"/> Depression (VN) |
| <input type="checkbox"/> Diverticulitis/osis (G) | <input type="checkbox"/> Insomnia (VN) |
| <input type="checkbox"/> Constipation (G) | <input type="checkbox"/> Tension/Stress |
| <input type="checkbox"/> Puffiness after eating (G) | <input type="checkbox"/> Anxiety (VN) |
| <input type="checkbox"/> Endometriosis (G) | |
| <input type="checkbox"/> Spinal Arthritis (MPS) | <input type="checkbox"/> Varicose Veins (L) |
| <input type="checkbox"/> Sciatica (MPS) | <input type="checkbox"/> DVT |

_____ Joint Replacement (MPS)
_____ Endometriosis (MPS)
Covid (L, MPS)
_____ Surgical scars. List: _____

_____ Coronary Disease (L)
_____ History of Lyme or
_____ HIV/AIDS
_____ Blood Pressure Issues

_____ Stents (DL)
_____ Aneurysm (DL)
(DL)
_____ Carotid Artery Issue (DL)
_____ Brain swelling/bleeding (DL)
_____ Cancer/Tumors

_____ Pacemaker(DL)
_____ Abdominal Mesh
_____ Infections (DL)

_____ Arthritis

_____ Herniated Disk

_____ Fibromyalgia

_____ Scoliosis

_____ Diabetes
_____ Hepatitis
_____ Pregnancy (currently)

_____ Carpal Tunnel
_____ Bursitis/Tendonitis
_____ Neuropathy

Signing below verifies that I:

... understand that the services offered are not a substitute for medical care, and that any information provided is for educational purposes only and is not diagnostically prescriptive. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and have answered all questions honestly. I agree to share updates of any changes in my medical profile and understand there should be no liability on the part of the therapist should I forget to do so.

... understand that any sexual remarks or advances will end the session, and I will be liable for full payment.

... will be charged for sessions missed without 24 hour notification, except for emergency. Also, after 15 minutes, session will be canceled and cancellation fee may be applied.

Signature: _____ Date: _____
