Carolyn Fitzgibbons, LAc, LMT, LLC
Acupuncture, Bodywork, Chinese Herbs

**Please bring with you to your first appointment
or email to: acubodyherbs@gmail.com

New Client Information

Legal Name: _____ Preferred Name: _____

Today's Date: _____ DOB: _____

Legal Gender: ☐ Male ☐ Female Preferred Pronouns: _____

Street Address, City, State, Zip Code:

_____

Home Phone: _____ Mobile Phone: _____

Email: _____

Please indicate how you would like to be contacted:

☐ Home Phone ☐ Mobile ☐ Text ☐ Email

What is best time of day to contact you?

☐ Morning (8 am – 12 pm) ☐ Afternoon (12 – 4 pm) ☐ Early Evening (4 – 7 pm) ☐ Late Evening (7 – 9 pm)

Your Occupation: _____

Marital Status: _____ Living Situation: ☐ Stable ☐ Unstable

How did you hear about my business?

☐ Google ☐ Facebook ☐ Instagram ☐ Referred By: _____

Emergency Contact

Emergency Contact Name: _____ Relationship to Client: _____

Home Phone: _____ Mobile Phone: _____

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Medical Intake Form

List the names & phone numbers of any doctors or practitioners you would like me to consult with:

_____

_____

_____

_____

What is the primary concern you would like to address in treatment?

_____

Other issues or concerns you would like to address?

_____

_____

_____

_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? ☐ Yes ☐ No

If yes, how often do you receive massage therapy? _____

Do you have any difficulty lying on your front, back, or side? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any known allergies to oils, lotions, or ointments? ☐ Yes ☐ No

If yes, please explain: _____

Do you have sensitive skin? ☐ Yes ☐ No

Are you wearing contact ☐ lenses ☐ dentures ☐ a hearing aid?

Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No

If yes, how long per day: _____

Do you perform any repetitive movement in your work, sports, or hobby? ☐ Yes ☐ No

If yes, please describe the movement: _____

Do you experience stress in your work, family, or other aspect of your life? ☐ Yes ☐ No

If yes, how do you think it has affected your health? _____

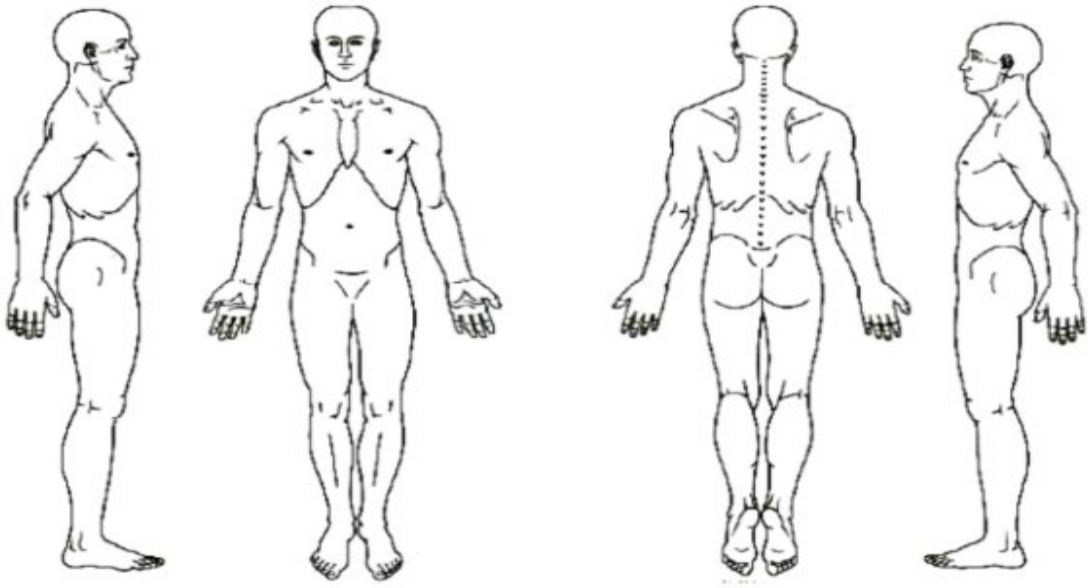
Does it cause ☐ muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other: _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

☐ Yes ☐ No

If yes, please identify: _____

Using an X, please indicate any areas of current pain or weakness of the diagram below:



How would you describe your pain? ☐ Sharp ☐ Dull ☐ Ache ☐Throbbing

How would you rate your pain on a scale of 1 – 10 (10 being as bad as it could be, nothing else matters):

_____

Does this pain move to another part of the body/other side of the body? ☐ Yes ☐ No

If yes, please explain: _____

Please list any past accidents, injuries or surgeries, including dates:

_____

_____

_____

Do you experience numbness and/or tingling in any part of your body? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently under medical supervision? ☐ Yes ☐ No

If yes, please explain: _____

Do you see a chiropractor? ☐ Yes ☐ No If yes, how often? _____

Please check any condition listed below that applies to you:

- ☐ Contagious skin condition
- ☐ Open sores or wounds
- ☐ Easy bruising
- ☐ Artificial joint
- ☐ Current fever
- ☐ Swollen glands
- ☐ Allergies/sensitivities
- ☐ Heart condition
- ☐ High or low blood pressure
- ☐ Circulatory disorder
- ☐ Varicose veins
- ☐ Atherosclerosis
- ☐ Phlebitis
- ☐ Deep vein thrombosis/blood clots
- ☐ Joint disorder
- ☐ Rheumatoid arthritis/osteoarthritis
- ☐ Tendonitis
- ☐ Osteoporosis
- ☐ Epilepsy
- ☐ Headaches/migraines
- ☐ Cancer
- ☐ Diabetes
- ☐ Decreased sensation
- ☐ Back/neck problems
- ☐ Scoliosis
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ Carpal tunnel syndrome
- ☐ Tennis elbow
- ☐ Pregnancy If yes, how many months _____

Please explain any condition that you have marked above: _____

_____

_____

Is there anything else about your health history that you think would be useful for your practitioner to know to plan a safe and effective bodywork session for you? _____

I, _____ (*print name) understand that the bodywork I receive is provided for the purpose of relaxation and/or relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a medical physician, chiropractor or other qualified medical specialist for any spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I acknowledge that any attempt to sexualize the bodywork session will result in the immediate termination of the session and I will be expected to still pay in full.

Signature of Client: _____ Date: _____

* Signature of Parent or Guardian: _____ Date: _____

* Name of Minor: _____

*Consent to Treatment of Minor: By my signature above, I hereby authorize the practitioner to administer bodywork techniques to my child or dependent as she deems necessary.

Signature of Practitioner: _____ Date: _____

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List of Medications & Supplements

Client Name: _____ **DOB: _____** **Today's Date: _____**

Please list ALL prescription and non-prescription drugs (i.e. over the counter, vitamins, supplements, herbs, etc.) currently being taken. Include any taken occasionally, such as aspirin for headaches, as well as those taken daily.

Medication/ Supplement Name (brand and/or generic name)	**Dose**	**How often do you take this?**	**Reason for Taking**	**Started When?**	**Who prescribed it?**

(Use back of page if needed.)

Medication/ Supplement Name (brand and/or generic name)	**Dose**	**How often do you take this?**	**Reason for Taking**	**Started When?**	**Who prescribed it?**