

Ki Soma LLC

NEW CLIENT INTAKE AND HEALTH HISTORY

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____ Preferred contact? Email. Phone. Text.

Referred by: _____

Emergency contact: _____ Relationship _____

Emergency Contact Phone: _____

Gender (genetic) : XX female ☐ XY male ☐ Gender (identify as) _____

Preferred pronouns _____

MESSAGE HISTORY

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

If so, what type and how recently? _____

What kind of pressure do you prefer? (circle one) Light Medium Firm

Are you sensitive to scents such as essential oils or room sprays? Yes ☐ No ☐

What are your goals/expected outcomes for receiving massage/bodywork?

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, digestive complaints, sleep disturbances, etc.):

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

If so, please explain:

List the medications you currently take:

Do you have any allergies? (Contact, Food or Medications) Please list:

Are you wearing contacts? Yes ☐ No ☐

Are you wearing body jewelry? Yes ☐ No ☐

Are you wearing dentures or hearing assistive device? Yes ☐ No ☐

Are you wearing a hairpiece or extensions? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐ Not sure, but trying to conceive. ☐

History of injuries or surgeries? (Include concussions, repeated strains/sprains)

Do you have any implanted devices or cosmetic/reconstructive implants? Yes ☐ No ☐

How long ago were they placed? _____

Can you lay with your face in a soft face cradle? Yes ☐ No ☐

LIFESTYLE FACTORS

General diet: _____

Exercise or movement habits: _____

Typical *daily* intake of: caffeine _____ cigarettes _____

iced beverages _____ alcohol _____ recreational drugs _____

Prefer not to answer ☐

Occupation: _____

Hobbies/relaxing activities:

Typical areas of tension in the body: _____

Ongoing caretaking activities: (of spouse, parent, child(ren))

CIRCLE ANY OF THE FOLLOWING HEALTH CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE BEEN DIAGNOSED WITH IN THE PAST. (IF YOU ARE UNSURE, WE'LL DISCUSS PLEASE ANSWER HONESTLY, AS BODY THERAPY MAY BE CONTRAINDICATED OR DELAYED FOR THE BELOW CONDITIONS.):

Blood clots? Current ☐ Past ☐

Currently on a blood thinner? Yes ☐ No ☐

Active skin infection or systemic infection? Current ☐ Past ☐

Congestive heart failure? Current ☐ Past ☐

Contagious disease? Current ☐ Past ☐

Pitting edema? Current ☐ Past ☐

Open wound? Current ☐ Past ☐

PLEASE CIRCLE ANY CONDITIONS THAT YOU HAVE, HAVE HAD IN THE PAST OR ARE CONSIDERED IN REMISSION.

Explain briefly and we'll discuss, including treatment received and whether you feel they are currently well managed:

Muscle or joint pain Current Past _____

Muscle or joint stiffness Current Past _____

Numbness or tingling Current Past _____

Swelling Current Past _____

Bruise easily Current Past _____

Hyper-mobile joints Current Past _____

Sensitive to touch/pressure Current Past _____

High/Low blood pressure Current Past _____

Stroke, heart attack Current Past _____

Varicose veins Current Past _____

Shortness of breath, asthma Current Past _____

Recurrent ear or sinus infections. Current Past _____

Lyme's Disease, POTS Current Past _____

Cancer Current Past _____

Neurological (e.g. MS, Parkinson's, chronic pain) Current Past Remission _____

(Auto)/Immunologic Current Past Remission _____

Epilepsy, seizures Current Past _____

Tics or Tourette's Current Past _____

Headaches, Migraines Current Past _____

Dizziness, ringing in the ears Current Past _____

Digestive conditions (e.g. Crohn's, IBS) Current Past _____

Gas, bloating, constipation/diarrhea Current Past _____

Kidney disease, infection. Current Past _____

Arthritis (rheumatoid, osteoarthritis) Current Past _____

Osteoporosis, degenerative spine/disk. Current Past _____

Scoliosis Current Past _____

Broken bones Current Past _____

Diabetes Type 2 Current Past _____

Type 1 Diabetes— Age at diagnosis _____ Insulin Pump and/or CGM? _____

Endocrine/thyroid conditions Current Past _____

Depression, anxiety, panic attacks Current Past _____

Memory Loss, confusion Current Past _____

Persistent Grief Current Past _____

PMS _____

Irregular periods Current Past _____

Learning differences _____

Phobia(s) or excessive fear(s) _____

CONSENT FOR TREATMENT

These types of bodywork are meant to be relaxing and without pain or discomfort. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. If the pressure feels too deep (i.e. you may sense yourself contracting away from my touch) or not deep enough (i.e. you may feel frustrated), or if an area is starting to feel overworked or you want me to move on or to do something differently to better encourage you to relax.

I understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. _____ (Initial)

I further understand that massage/bodywork practitioners are not qualified to, 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. _____ (Initial)

For my own health and safety, massage/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. Understanding all of this, I give my consent to receive body work today and moving forward. _____ (Initial)

The following sometimes occurs during Shiatsu and Cranio-sacral therapies. They are *normal* responses to relaxation. Trust that your body knows what it needs to do. There is no need to suppress their happening as it will only introduce stress into a session meant for your relaxation and comfort.

*need to move or change position, even frequently *sighing, yawning, change in breathing
*stomach gurgling *movement of intestinal gas *energy shifts *emotional feelings and/or expression *memories *falling asleep/snoring

Your session can be stopped at anytime you wish, if you are feeling uncomfortable, overwhelmed or other sensation that is not relaxing or feels counterproductive to your goals.

Client Signature: _____

Date: _____

Parent or Guardian Signature (in case of a minor): _____

Relationship to minor client: _____

Date: _____