Client Intake Form

STARR Clinic

Client Contact Information

Client Name (名前): ____ Date: _______________

Date of Birth (生年月日): _________________ Gender (性別): ________ Occupation (職業):____________

Address (住所): _____________________ City / Province: ______ Postal code (郵便番号): _______________

Phone (電話番号): _______________________________ Email: ____

Referred by (ご紹介者氏名): _________________ Emergency contact/Phone#:____________/_____________
(緊急連絡先/電話番号)

Massage Information

Is this massage medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Have you ever received professional massage therapy/bodywork before? Yes ☐ No ☐
What types of massage/bodywork have you received? ____

Last treatment: ______________________________ how often? _______________________________________

What kind of pressure do you prefer? Light Medium Firm

Current Health

Do you exercise regularly and/or play any sports? Yes ☐ No ☐
If yes, what kind of exercise/sports? ____

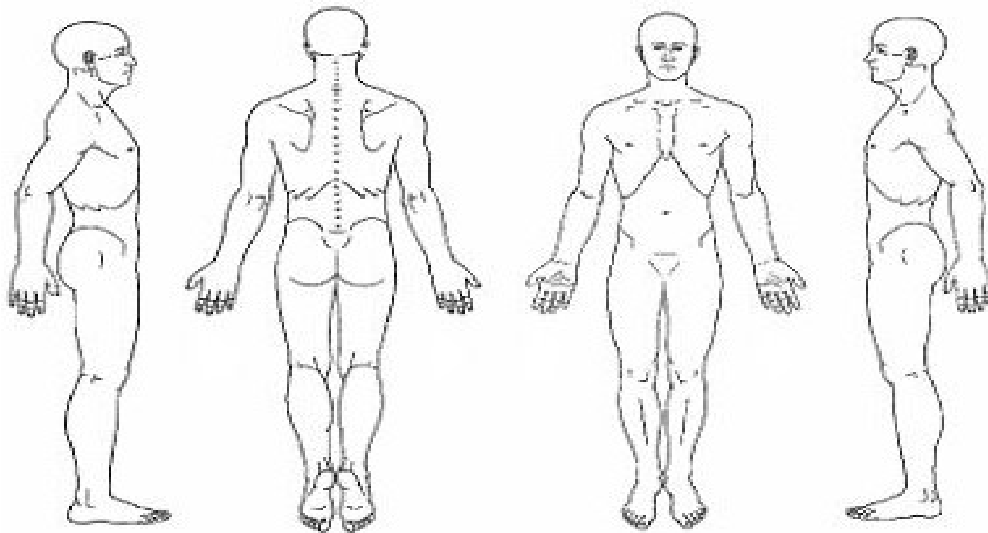
Do you perform any repetitive movements in your work, sports, or hobby? Yes ☐ No ☐
If yes, describe: ____

Do you sit for long hours at a workstation/computer or driving? Yes ☐ No ☐
If yes, describe: ____

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

List the medications you currently take: ____

***Please indicate on the diagram below areas of pain and tightness with an "X" and areas that you want to be worked on with an "O". (痛みや筋肉の硬直が強く感じられる箇所に"X"を痛みなどを緩和されたい箇所に"O"をご記入下さい。)**



Are you a smoker? (喫煙されますか？) Yes ☐ No ☐
Are you wearing dentures? (入れ歯をされていますか?) Yes ☐ No ☐

Client Intake Form

STARR Clinic

Health History 該当する項目にチェックして下さい。

Musculoskeletal(筋骨格)	**Nervous System(神経系)**	**Digestive(消化器系)**
__Bone or Joint Disease(骨や間接の病気) __Tendonitis(腱炎)/Bursitis(滑液包炎) __Arthritis/Gout (関節炎・痛風) __Jaw Pain(あごの痛み) __Lupus(ループス) __Spinal Problems(脊髄の問題) __Migraines/Headaches(偏頭痛・頭痛) __Osteoporosis(骨粗鬆症) __Muscle or Join Pain(筋肉・関節痛) __Scoliosis(脊柱側弯症) __Broken bones(骨折) __Herniated Disc(ヘルニア) (Where? _____)	__Shingles(帯状疱疹) __Numbness/Tingling(麻痺) __Pinched Nerve(神経痛) __Chronic Pain(慢性痛) __Paralysis (麻痺) __Multiple Sclerosis (多発性硬化症) __Parkinson's Disease (パーキンソン病) __Epilepsy, Seizures (てんかん・発作) __Sciatic Symptoms (坐骨神経症状)	__Irritable Bowel Syndrome (過敏性腸症候群) __Bladder/Kidney Ailment (膀胱・腎臓疾患) __Colitis (大腸炎) __Crohn's Disease (クローン病) __Ulcers (潰瘍)
Respiratory(呼吸器系)	**Reproductive(生殖器系)**	**Psychological(心理学)**
__Breathing Difficulty/Asthma(喘息) __Emphysema(肺気腫) __Allergies(アレルギー) Specify(具体的に): _______________ __Sinus Problems(副鼻腔の疾患)	__Pregnant(妊娠), Stage(妊娠の周期) _________ __Ovarian/Menstrual Problems (卵巣・月経の問題) __Prostate(前立腺)	__Anxiety/Stress Syndrome (不安/ストレス症候群) __Depression(うつ病) __Insomnia (不眠症)
Circulatory(循環器系)	**Skin(皮膚)**	**Other(その他)**
__Heart Condition (Stroke, Heart Attack) (脳卒中・脳梗塞・心臓発作) __Varicose Veins(静脈瘤) __Blood Clots (血餅・凝血塊・血栓・塞栓) __High/Low Blood Pressure (低血圧・高血圧)	__Allergies(アレルギー), specify(具体的に): _________________ __Rashes(発疹) __Cosmetic Surgery(整形手術) __Athlete's Foot(水虫) __Herpes/Cold Sores (ヘルペス・口辺単純疱疹) __Bruise easily(あざになり易い)	__Cancer/Tumors(癌・腫瘍) __Diabetes(糖尿病) __Drug/Alcohol/Tobacco Use (薬物・アルコール・タバコ) __Contact Lenses(コンタクトレンズ) __Dizziness, Ringing in ears (めまい・耳鳴り) __Hearing Aids(補聴器) __Thyroid condition(甲状腺の病気) __Memory loss, confusion, easily (記憶障害・混乱し易い)

Any other medical condition(s) not listed (上記の項目にない症状や病気をお持ちの方はご記入下さい)：

____

Please explain any of the conditions that you have marked above (上記の項目にチェックマークをご記入された方はその症状や病気の詳細をご記入下さい): ____

Have you had any injuries or surgeries in the past or recently that may influence today's treatment? (指圧を施術するにあたり、過去や最近の怪我や手術による後遺症をお持ちの方はご記入下さい)：

____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):

blood clots / infectious skin disease / congestive heart failure / contagious diseases / pitted edema / open wounds / recent surgeries / on blood thinners / high risk pregnancy / abdominal hernia / immediate after chemotherapy or radiation / osteoporosis

****Please answer honestly, as massage may not be indicated for the above conditions without consulting with your Doctor.**

Consent for Treatment

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

I understand that massage/bodywork practitioners are not qualified to perform 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 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Right of Refusal
STARR Clinic therapists reserve the right to refuse any treatment if a patient is deemed to be under the influence of alcohol or any recreational drugs, or if there is any inappropriate comments or behaviours. You as the Client are to be advised that you may change or refuse any or all parts of the treatment now or at anytime.

Cancellation Policy
A minimum of 24 hours notice is required if you are unable to keep your scheduled appointment. If you fail to show up for your appointment or if you cancel an appointment without sufficient notice, you agree to pay the full cost of the treatment. This Cancellation Policy applies to each appointment you make.

STARR Clinic Disclaimer
You the Client agree that you will not hold STARR Clinic responsible for any lost or stolen items, as well as any personal injuries, that occur during your scheduled treatment with our in-house therapist from STARR Clinic.

Client Signature: ____ Date: _____________

Parent or Guardian Signature (in case of a minor): ________________________ Date: _____________