Ludwig Studio

Therapeutic Massage & Bodywork
Specializing in JFB Myofascial Release & Equine MFR
c: (703) 939-7976 165 Devon Road, Williamsburg, VA 23188 john@ludwigstudio.net

Client Intake Form

Name _____ Date of Birth ___/___/___ Today's Date___/___/___
Phone (Circle Preferred): Work _____ Home _____ Cell _____
Fax _____ E-mail _____
Address _____ City _____ State _____ Zip _____
Emergency Contact: Name _____ Phone _____
How did you hear about me? _____

Health Data

Have you had a massage before? Yes ☐ No ☐ If Yes, what for/how often?

_____

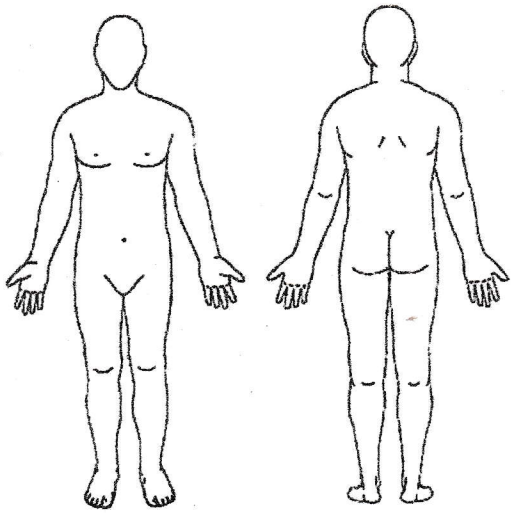
Please describe your daily living/work duties and environment (ex:: desk work/big company; athlete/semi-pro team, construction work/heavy lifting, etc.): _____
Do you have any allergies/sensitivities? Yes ☐ No ☐ If Yes, to what? _____
Any injuries or illness in the past 72 hours? Yes ☐ No ☐ If Yes, please explain: _____
Have you ever had a major illness or surgery? Yes ☐ No ☐ If Yes, what was it, doctor's name and date:

_____

Are you taking any medications (any prescriptions, over-the-counter, vitamins or herbal supplements)? Yes ☐ No ☐
If Yes, please list with dosage(s): _____
Do you have any conditions that I should know about? Yes ☐ No ☐ If Yes, please explain:

_____

Reason for visit: _____



Please mark on the figures any areas of:

-Pain/tenderness with X's
-Numbness/tingling with ZZ's
-Swelling with S's
-Scars, bruises open wounds with HH's

Please rate pain/discomfort level:
(1 = perfectly O.K.; 10 = put me out of my misery)

1 2 3 4 5 6 7 8 9 10

Consent for Care

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. Should I have to cancel an appointment for any reason, I agree to give the therapist at least 24 hours notice.

Name _____ Signature _____ Date ___/___/___