



Grief Massage Client Intake

Name:

Preferred Pronoun:

Date of birth:

Routines (circle 'Yes' or 'No'):

- I have a well established morning routine that sets an intentional tone to my day
Yes No
- I have a well established bedtime routine that cues my brain to wind down and get ready for sleep.
Yes No
- I have no established routines for either morning or night.
Yes No

Why are you seeking treatment?

Have you had a recent loss (current year)? Yes No

If yes, what kind? When?

Have you had previous losses? Yes No

If yes, what kind? When? Please list all

List all major injuries/surgeries:

Conditions (Circle all that apply):

Depression (diagnosed)	Sleep issues	Mood swings
Anxiety	Fear	Apathy
Anger	Loss of appetite	Crying
Exhaustion	Guilt	Forgetfulness
Resentment	Nervousness	Irritability
Sadness	Difficulty thinking	Racing thoughts
Gut/digestive issues	Long term Covid symptoms	Other (fill in)

Therapies (Circle all therapies you've tried):

Massage therapy	Acupuncture	Hydrotherapy
Aromatherapy	Sound therapy	Yoga
Float tank	Tai Chi	Meditation
Dance therapy	Reiki	Rolfing
Storytelling	Breathwork	EMDR
EFT	Visualization	None

Other therapy not listed:

Self-Care (Circle all self care you've tried. These are activities you do on your own without a practitioner, group, or class):

Journaling	Creating a sanctuary	Breathwork
Stretching/movement	Listening to music	Painting
Gardening	Cooking	Meditation
Baths	Aromatherapy	Reading
Other (fill in):	Other (fill in):	Other (fill in):

Other self-care activity not listed:

List all physical activities/exercise/movement: