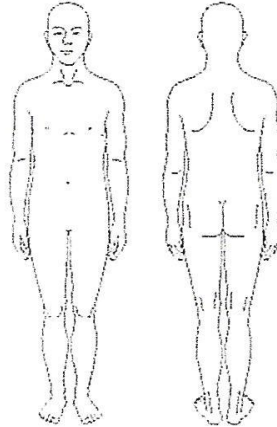


## CLIENT INTAKE FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Primary Complaint: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

*Please mark and label the diagram with aches, pains, numbness, or other problems.*



- X – Stabbing Pain
- O – Numbness
- //// - Aches
- +++ - Pins and Needles
- Burning

Have you ever had a professional massage before? YES/NO \_\_\_\_\_  
 Are you under the care of any health care professional? YES/NO \_\_\_\_\_  
 Are you taking any medications? \_\_\_\_\_

If you have any recent or chronic medical conditions, please check them below and discuss them with your massage therapist.

Have you had or do you have any of the following:

- |                                                |                                                                                                             |                                                     |
|------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> jaw pain/injury       | <input type="checkbox"/> Back discomfort or injury                                                          | <input type="checkbox"/> neck discomfort            |
| <input type="checkbox"/> headaches             | <input type="checkbox"/> high blood pressure                                                                | <input type="checkbox"/> circulatory/heart problems |
| <input type="checkbox"/> anemia                | <input type="checkbox"/> varicose veins                                                                     | <input type="checkbox"/> blood clotting disorder    |
| <input type="checkbox"/> epilepsy              | <input type="checkbox"/> malignant condition or cancer                                                      | <input type="checkbox"/> muscle cramping            |
| <input type="checkbox"/> respiratory problems  | <input type="checkbox"/> fainting spells or dizziness                                                       | <input type="checkbox"/> ulcers                     |
| <input type="checkbox"/> digestive problems    | <input type="checkbox"/> neurological problems                                                              | <input type="checkbox"/> diabetes                   |
| <input type="checkbox"/> numbness/tingling     | <input type="checkbox"/> recent surgery (explain on back)                                                   | <input type="checkbox"/> TB                         |
| <input type="checkbox"/> herniated disks       | <input type="checkbox"/> allergies ( <input type="checkbox"/> to essences <input type="checkbox"/> to oils) | <input type="checkbox"/> dentures                   |
| <input type="checkbox"/> fractures/bone trauma | <input type="checkbox"/> dislocations/sprains/strains                                                       | <input type="checkbox"/> arthritis                  |
| <input type="checkbox"/> currently pregnant    | <input type="checkbox"/> alcohol in the last 3 hours                                                        | <input type="checkbox"/> contact lenses             |
| <input type="checkbox"/> car accidents         | <input type="checkbox"/> fibromyalgia                                                                       | <input type="checkbox"/> chronic fatigue            |
|                                                |                                                                                                             | <input type="checkbox"/> nut allergy                |

Do you have any other medical condition that your practitioner should be aware of before performing your massage? \_\_\_\_\_

Please read before signing:

I understand that the purpose of this massage is for stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals. This massage session is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailment that I have. I understand that massage therapists need to be aware of existing physical conditions; therefore, I have stated all of my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. I also understand that any illicit or sexually suggestive behavior, 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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_