Client Intake Form

Contact Information

Name _____ Date of Birth _____
Address _____ City _____ State ___ Zip_____
Home Phone _____ Work Phone _____
Email _____
Occupation _____

Emergency Contact _____
Relationship _____ Phone _____

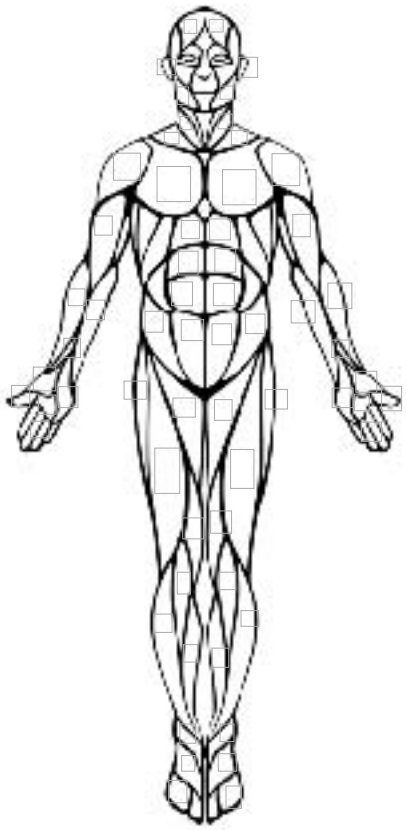
How did you hear about us? _____

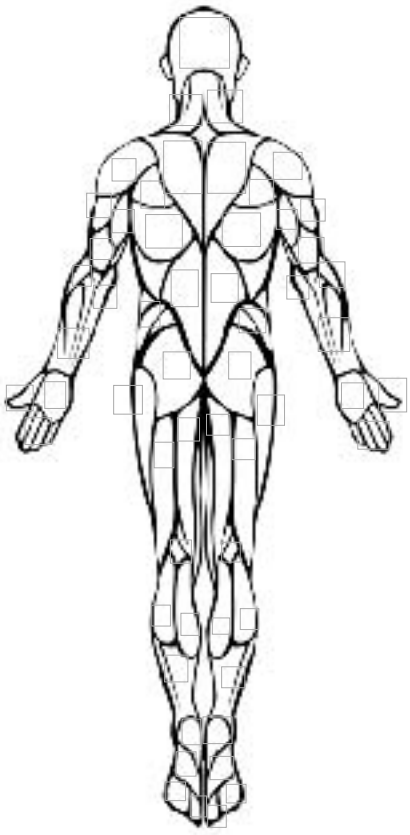
Your Session

What are you looking primarily for in your massage today?

☐ Full Body Experience ☐ Precise Therapeutic Attention ☐ Both

Please use the diagram below to indicate areas of tension or discomfort





I would like my massage to be more:
Smooth and Flowing.....Deep and Focused

1 2 3 4 5 6 7 8 9 10

My tolerance for pressure is:

I am a delicate rose petal.....I don't feel pain

1 2 3 4 5 6 7 8 9 10

Medical History

Do you exercise regularly? Yes No
Type: _____

Are you currently under the care of a physician? Yes No
Name, phone number, and what for _____
_____

Are you using any medications or other substances? If yes, please list below:
_____

Please list any surgeries, accidents, or major illnesses
_____

Please review the following list and check those conditions that have affected your health either recently or in the past:

___ Arthritis
___ Asthma
___ Diabetes
___ Blood Clots
___ Back Problems/Scoliosis
___ Broken/Dislocated bones
___ Bruise Easily
___ Cancer
___ Chemical Dependency
___ Chronic Fatigue
___ Chronic Pain
___ Constipation/Diarrhea
___ Depression, Panic Disorder, or other Psych Conditions
___ Diverticulitis
___ Headaches
___ Heart Condition
___ Hepatitis
___ Insomnia
___ Muscle Strain/Sprain
___ Pregnancy
___ Seizures
___ Skin conditions/Rash
___ Surgery
___ Tendonitis/Bursitis
___ TMJ Disorder
___ Vericose Veins
___ Whiplash

Any Communicable Diseases? _____

Consent for Care

Please read the following and sign below:

1. I understand that although massage therapy can be very therapeutic, it is NOT a substitute for medical examination, diagnosis and treatment.
2. I acknowledge that massage should not be done under certain medical conditions and I affirm that I have answered all questions pertaining to medical conditions truthfully. I will inform my practitioner of any changes in my health status, and all important communication from other care practitioners.
3. I understand that this is a therapeutic massage and any sexual remarks or advances will terminate the session, and I will be liable for payment of the scheduled treatment.

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.

Client Signature _____ Date _____