

Client Intake Form

Contact Information

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

Emergency Contact _____
Relationship _____ Phone _____

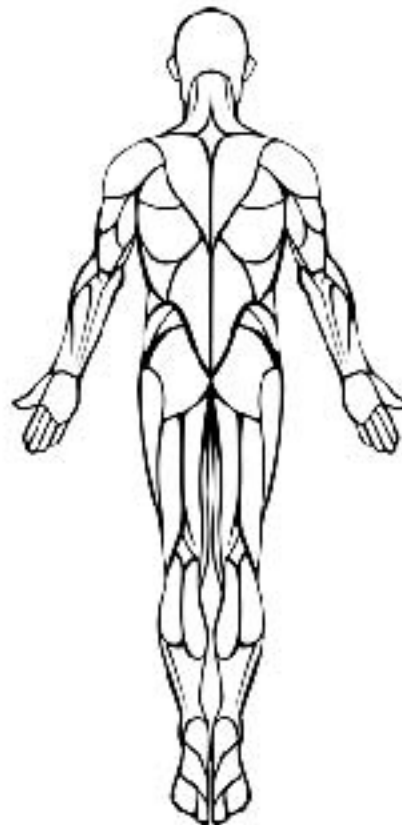
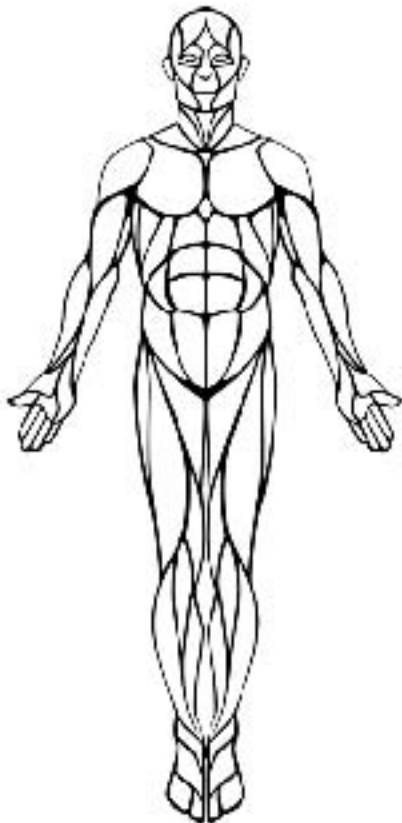
How did you hear about us? _____

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:

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Back Problems/Scoliosis | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Broken/Dislocated bones | <input type="checkbox"/> Muscle Strain/Sprain |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Skin conditions/Rash |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Tendonitis/Bursitis |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Depression, Panic Disorder,
or other Psych Conditions | <input type="checkbox"/> Varicose Veins |
| | <input type="checkbox"/> 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 _____