Client Intake Form

Date: _____

Name: _____ Sex: _____ Male ____ Female

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Alterative Phone #: _____

Email: _____ Birth date: ___/___/___ Age: _____

How do you prefer to be addressed? _____ How did you hear about me? _____

Occupation: _____ Employer: _____

Have you had a professional massage before? _____ How often: _____ Type: _____

Do you wear Contacts? _____ Are you pregnant? _____

Are you currently under a doctor's care? _____ Please explain: _____

_____

Do you have a history of the following? Please check if "yes".

Musculoskeletal:
___Bone or joint disease
___Arthritis
___Sprains/Strains
___Low back pain
___Mid/Upper back pain
___Hip/Leg pain
___Neck pain
___Shoulder/Arm pain
___Headaches
___Jaw pain/Clicking/Popping
___Clenching or Grinding teeth
___Spasms/Cramps
___Spinal Curvature
___Fibromyalgia
___Other _____

Digestive:
___Constipation
___Gas/Bloating
___Hiatal hernia
___Other_____

Neurological:
___Herpes/Shingles
___Numbness/Tingling
___Chronic Pain
___Dizziness (any cause)
___Other_____

Genitourinary:
___Kidney Infections
___Kidney Stones
___Prostate Problems
___Other_____

For Women Only:
___Painful Menstruation
___Yeast Infections
___Breast lumps/masses
___Other_____

Respiratory/Circulatory:
___High blood pressure
___Breathing difficulties
___Varicose veins
___Other cardiovascular problems
___Other_____

Other:
___Allergies (any)
___Cancer/tumors
___Sinus problems
___Fatigue
___Difficulty Sleeping
___Diabetes
___Drug/Alcohol addiction
___Other_____

Infectious Disease: ___Disease name(s)
_____

Nicotine/caffeine use: _____

Lymph Node Removal: _____If yes, location: _____

Skin:
___Rashes ___ Bruise easily ___ Sensitive skin ___Hives/allergies ___Other_____

Are you taking any prescription or over the counter medications? _____

_____

Illnesses: _____

Injuries: _____

Surgeries: _____

In Case of Emergency, Please Notify: Name: _____

Telephone #: _____ Relationship: _____

Payment will be: ___Check ___Cash ___Gift Certificate ___Credit Card ($5 processing fee applies)

I understand that a block of time has been set aside for my treatment and requires me to give no less then 12 hours notification for cancellation; failure to do so could result in a fee or prepayment for my next treatment.
_____

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical, chiropractic treatment or pharmaceuticals. It is in no way intended to be a substitute for professional health care. I have stated all medical conditions of which I am aware, and will update the therapist of any changes in my health status.
Signature: _____ Date: _____