Client Intake Form

Name:_____ Date of Birth:____/____/_____

Mailing Address:_____

City, State, Zip: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

E-mail Address:_____

Occupation: _____ Work Phone: (_____)_____-_____

Referred By: _____

What is the best way to contact you? □ Home □ Cell □ Work □ E-mail

Emergency Contact: _____ Relationship:_____

Phone: (_____)_____-_____ Alternate Phone: (_____)_____-_____

Goal For Today's Session: □ Relaxation □ Bodywork

General & Medical Information

Have you ever had a professional massage? **Yes No**

Are you pregnant? **Yes No** If yes what trimester?_____

Are you currently suffering from a cold or fever? **Yes No**

Do you have tension or soreness in a specific area? **Yes No**

Explain:_____

Are you experiencing any numbness or stabbing pain? **Yes No**

Explain:_____

Are you sensitive to pressure or touch in any areas? **Yes No**

Explain:_____

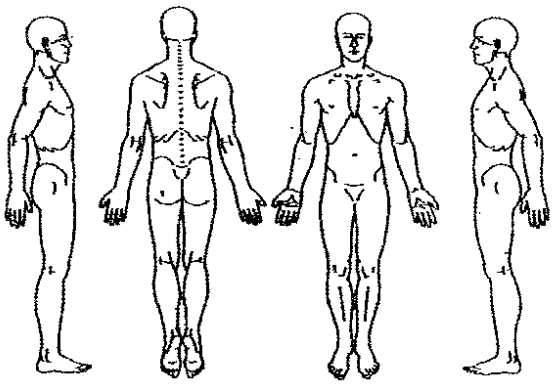
Do you exercise regularly? **Yes No** How often _____

What type(s)_____

How many glasses of water do you drink per day? _____

How would you classify your level of stress? **Low Med High**

Mark the area(s) of pain/tension below:



Do you have now or have you ever had:

Frequent headaches	Yes No	Asthma	Yes No
Varicose veins	Yes No	Skin disorders	Yes No
Surgery	Yes No	Allergies	Yes No
Cardiac or circulation problems	Yes No	Cancer	Yes No
Diabetes	Yes No	Broken bones	Yes No
High or low blood pressure	Yes No	Rash, broken skin, or bruises	Yes No

If the answer to any of the above questions is ***yes*** please explain below: _____

_____

_____

Are you currently under the care of a physician? If yes please explain:_____

_____

Are you taking any medication? **Yes No** If yes please list and explain: _____

_____

Do you have any other medical conditions that I should be aware of? _____

_____

Please take a moment to carefully read the information you have provided and sign where indicated.
The above information is accurate to the best of my knowledge. I agree to update the massage therapist in regard to any changes in my heath and understand that there shall be no liability on the therapists part should I forget to do so.

Client Signature _____ Date _____