Client Intake Form

Name: _____ DOB: _____ Intake Date_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Incase of Emergency: _____
Are you at least 18? Yes No If no, a guardian must also sign this form prior to the massage.
Occupation: _____
Hobbies: _____
Any repetive motions? Yes No Please describe: _____
_____
Area(s) of concern: _____
Bruises, cuts or surgical scars? Yes No Where?: _____
Area(s) to avoid during masssage: _____
Allergies: _____
Have you had a professional massage before?: Yes No
Are you under the care of a doctor?: Yes No
Are you on any medications?: Yes No List:_____
_____
Favorite color: _____
Goal for this session: _____
Would you like a reminder call for future appointments? Yes No

Please check all that apply:

__Blood clotting disorder
__High blood pressure
__Anemia
__Nausea
__Epilepsy
__Numbness/tingling
__Dislocations/sprains/strains
__Fracture/bone trauma
__Car accident
__Muscle cramping
__Skin conditions/rash
__Digestive issues
__Diabetes
__Dentures
__Have you had alcohol in the last hour?
__Circulation/heart problems
__Varicose veins
__Headaches
__Fainting/dizziness
__Neurological problems
__Herniated disks
__Arthritis
__Back/neck discomfort/injury
__Jaw pain
__Cancer
__Respiratory problems
__Ulcers
__TB/other communicable diseases
__Contacts
__Are you pregnant?

Any other medical conditions your therapist should be aware of? _____
_____

Signature:_____ Date: _____
Guardian Signature: _____ Date: _____