CLIENT INTAKE FORM

CLIENT INFORMATION

Name:		D.O.B:
Address:		
City:	State:	Zip Code:
Phone #:	Occupation:	
Email:		
Emergency Contact:	Phone #:	

MASSAGE INFORMATION

Have you ever previously received professional massage therapy?

☐ Yes ☐ No

Type(s) of massage(s) experienced?

Describe:_____

Do you have any orthopedic injuries? ☐ Yes ☐ No

Describe:_____

Do you have chronic pain? ☐ Yes ☐ No

Describe:_____

Do you exercise regularly? ☐ Yes ☐ No

Do you have any of the following?:

☐ Contact Lenses ☐ Dentures

☐ Hearing Aids ☐ Plastic/Bone Cement/ Metal Implants

☐ Prosthetics ☐ Sensitive Skin

What type of massage do you prefer/require?

☐ Relaxation ☐ Therapeutic/Deep Tissue

☐ Other: _____

What pressure do you prefer/require?

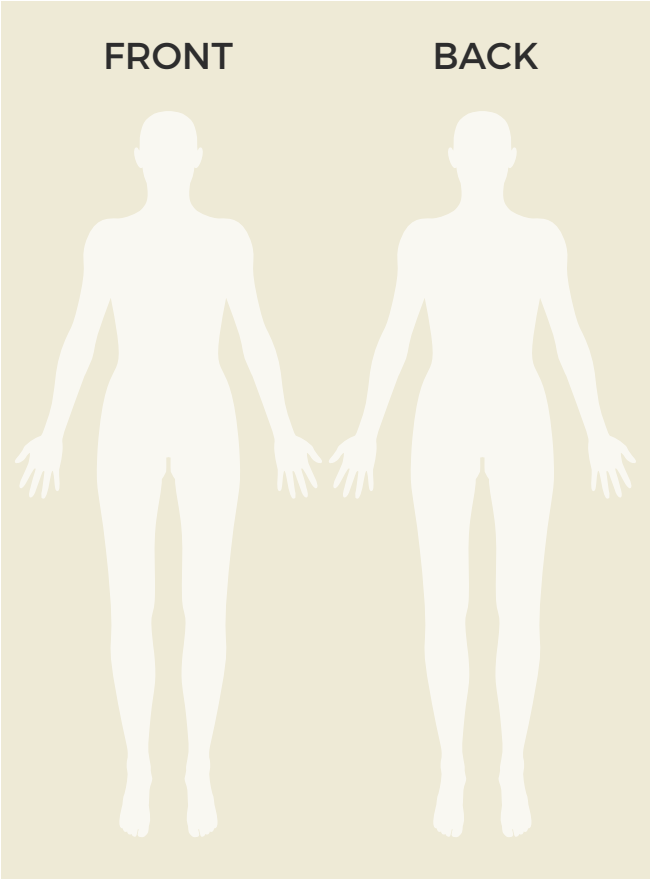
☐ Light ☐ Medium ☐ Firm

Goals for this treatment session?

_____

AREAS OF FOCUS

Please indicate with an [X] on the diagrams below the areas you would like to focus on, are feeling tense, or are experiencing discomfort:



MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cardio/Vascular Issues
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Depression
- ☐ Easily Bruises
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fatigue
- ☐ Fever
- ☐ Fibromyalgia
- ☐ Fungal Condition
- ☐ Headaches/Migraines
- ☐ Heart/Liver/Kidney Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hives/Herpes/Shingles
- ☐ Hyper/Hypo Thyroid
- ☐ Hypertension
- ☐ Inflammation
- ☐ Insomnia
- ☐ Loss of Sensation
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Poor Circulation
- ☐ Pregnant/Breast Feeding
- ☐ Psoriasis
- ☐ Rashes
- ☐ Recent Surgical Incisions
- ☐ Respiratory Conditions
- ☐ Sciatica
- ☐ Sinus Infection
- ☐ Sensory Loss
- ☐ Skin Cancer
- ☐ Skin Conditions/ Disorders
- ☐ Stress
- ☐ Stroke
- ☐ Transplant(s)
- ☐ Unhealed Wounds
- ☐ Varicose Veins
- ☐ Vertigo/Dizziness
- ☐ Seasonal Allergies
- ☐ Other _____

_____

_____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please explain:

Do you have any allergies/sensitivities to fragrances, oils, lotions, fruits, or nuts? ☐ Yes ☐ No

If yes, please explain:

Do you smoke, consume alcohol or caffeine? ☐ Smoke ☐ Alcohol ☐ Caffeine ☐ None

If yes, how much/often:

HEALTH CONCERNS/MASSAGE CONSENT

Do you have any of the following today? Please check all that apply:

- ☐ Cold/Flu
- ☐ Headache
- ☐ Hives/Rash
- ☐ Inflammation
- ☐ Open Wounds/Bruises
- ☐ Poison Ivy
- ☐ Severe Pain
- ☐ Sunburn

Would you like to be added to our email list for specials and discounts? ☐ Yes ☐ No

How did you hear about us?:

I understand that this form and it's data are completely confidential. The information I have provided regarding my medical history is accurate to the best of my knowledge, and I affirm I do not have any ailments or conditions that would make this treatment incompatible with my health and wellbeing. By signing this form, I certify that I am at least 18 years of age and fully competent to give my consent; that I have been given the opportunity to ask any questions I may have, and those questions have been answered. I acknowledge the information given to me pertaining to the requested treatment, and I have been sufficiently informed of the benefits and risks involved. I agree to inform my Technician if I experience any pain, discomfort, or sensitivities during treatment, allowing for them to make the appropriate adjustments. I understand that this massage is for stress/pain reduction, relaxation, relief from muscular tension, and it is not a form or replacement for medical care. No spinal/skeletal adjustments will be made, and no diagnosis will be given.

Client Signature: Technician Signature: Date: