Client Intake Form

Personal Information

Name (First, M.I., Last)________________________________ Date of Birth________________________
Address________________________________ Telephone________________________
City/State/Zip________________________________ Business Ph________________________
Occupation________________________ Employer________________________________
Email address:____
Emergency Contact Name/Relationship________________________ Telephone________________

Health Information

What is your main activity at work? (sitting, walking, computer work, phone, driving, etc)________________________
____
What activities do you perform to relax? (reading, yoga, meditation, breathing exercises. Etc) ________________________
What sports or physical activities do you participate in?________________________________
Do you find it difficult to relax? Y N Which hand is your dominant hand? Right Left

Note: Massage affects various systems of the body including increasing blood circulation. While this is normally beneficial, some conditions can be spread through the blood or skin. For your health and safety, please answer the following questions as completely and accurately as possible. Your information is confidential and will not be shared with anyone without your prior knowledge and signed consent.

General Health Condition________________________________ Blood Pressure________________
Have you had any serious or chronic illness, operations, chronic viral infections, traumatic accidents, or recent surgeries? Y N
If yes, please describe____
Are you in recovery for addictions or abuse? Y N
If female, are you pregnant? Y N Estimated Due Date:________________________
Are you under a doctor's, chiropractors, or other health practitioner's care? Y N
If so, for what condition?____
Are you taking medications/vitamins? Y N If so, please list type/dosage________________________
____
Do I have permission to contact your doctor/therapist? Y N
Names of doctors, chiropractors, health practitioners

Name________________________ Name________________________
Address________________________ Address________________________
Telephone________________________ Telephone________________________

Please check the following conditions that apply to you:

[ ] AIDS/HIV
[ ] Allergies
[ ] Anxiety
[ ] Arthritis
[ ] ADD/ADHD
[ ] Asthma
[ ] Clotting Disorder/Hemophelia
[ ] Cancer/Tumors
[ ] Candida/Yeast
[ ] Chronic Pain
[ ] Chronic Fatigue
[ ] Depression
[ ] Diabetes
[ ] Headaches/Migraines
[ ] Hepatitis
[ ] High/Low Blood pressure
[ ] Infectious Disease
[ ] Jaw pain/teeth grinding/TMJ Disorder
[ ] Low back pain/ruptured or bulging discs
[ ] Muscle/Joint pain
[ ] Numbness/Tingling/Burning sensation
[ ] Osteoporosis
[ ] Phlebitis
[ ] Physical/Emotional Abuse
[ ] Scoliosis
[ ] Sleep Difficulties
[ ] Sinus Problems
[ ] Skin Problems/Allergies
[ ] Sprains/Strains
[ ] Tendonitis
[ ] Tuberculosis
[ ] Varicose Veins
[ ] Vision Problems

If you checked any of the illnesses above, or if you have a condition that is not listed above, please describe________________
____
____
Date of onset________________ Treatment (type of treatment, current, past, etc) ________________________
____
Are you ill now? Y N If yes, please describe________________________________
Are you in remission? Y N For how long? ________________________________

Why are you receiving our services? (relaxation, pain, therapy, etc.)____

If you have indicated that you are experiencing pain or other symptoms, please indicate the areas on the diagram below.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
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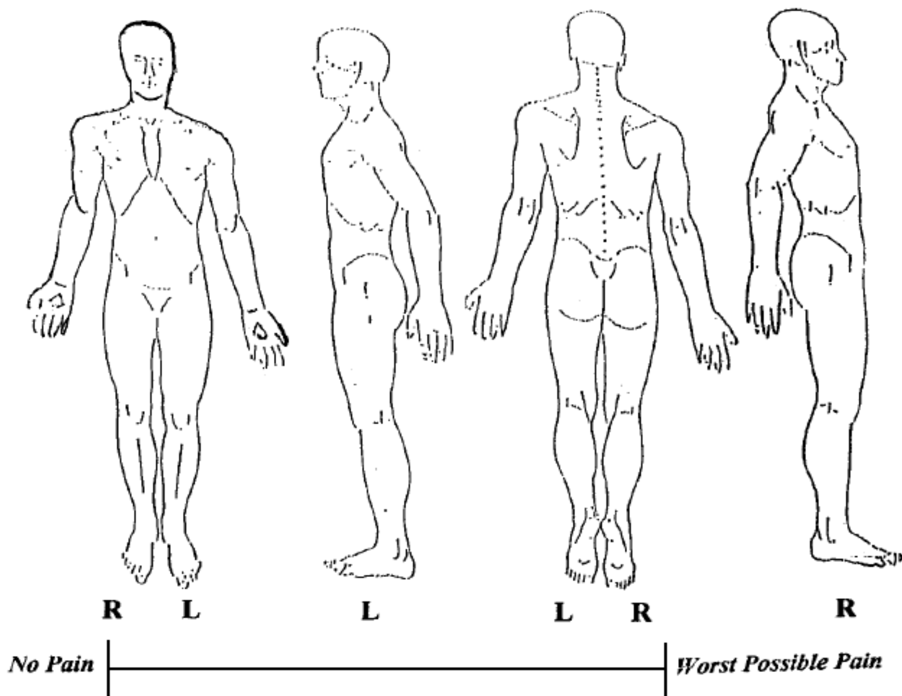
^^^	- - -	00	....	/////	X X X



What results would you like to achieve with our work? ____
Have you received massage therapy before? Y N If yes, by whom?____
When was your last massage?____
Please fill in any areas to be avoided: [ ] Breasts [ ] Gluteals [ ] Other ____
Are you ticklish? Y N If so, where?____
What type of massage would you like to receive today?
[ ] Therapeutic [ ] Relaxing [ ] Deep Tissue [ ] Pregnancy [ ] Fertility/Stimulating [ ] Sports [ ] Assisted Stretching [ ] Lymphatic
How did you find out about our services?____
If referred by a friend, please list his/her name so we may thank them____

My signature indicates that I have completed the form to the best of my knowledge. I understand that massage services are designed to be a health aid, and are in no way to take place of a doctor's care when it is indicated. Information exchanged during any session is not a diagnosis, and is educational in nature, intended to help me become more familiar and conscious of my own health status, and is to be used at my own discretion.

I have been informed that the massage can be terminated the massage by myself, or by the therapist at any time, for any reason.

I understand that this massage is for therapeutic, and/or relaxation purposes only, and that NO sexually suggestive or inappropriate conduct or requests will be tolerated. If this agreement is violated, the massage will immediately be terminated, client will be charged full price for the session, and immediately discharged from care.

Our time together is precious, and I agree to cancel 24 hours in advance. Unless there is an emergency, if I miss an appointment, I agree to pay the full appointment fee.

Date____________________________ Signature____

Date____________________________ Therapist Signature ____