Client Intake Form

Personal Information

Name ____ Date of Initial Visit ___________________________

Home Phone ________________________ Cell ________________________ Text ok? ☐ yes ☐ no

Best way to reach you? ☐Text ☐ E-mail

Address ____ City/State/Zip __________________________________

DOB (mm/dd) ______________________ Email ____

Primary Physician ____ Physician Phone _________________________________

Emergency Contact __________________________________ Phone _______________________________

Medical Information

Please list any condition you currently take medications for (Ex: Blood pressure): ________________________________

____

Are you pregnant? ☐ yes ☐ no How many weeks? ________

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, where: ____________________________________

Have you ever broken a bone? ☐ yes ☐ no

If yes, what: _____________________________________

Have you ever had any surgeries? ☐ yes ☐ no

If yes, please list: ________________________________

____

Is the use of oils ok during your massage? ☐ yes ☐ no

Please indicate any of the following that apply to you currently.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Varicose Veins
☐ Edema (swelling)
☐ Bulging/Herniated Disc
☐ Fibromyalgia
☐ Stroke/Heart Attack
☐ Eczema/Psoriasis
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness/Tingling
☐Sprains or Strains
☐ Muscle Spasms
☐ Cellulitis
☐ Bruising

Explain any conditions you have marked above:

____

____

☐ **I understand that if I do not show up for an appointment I will be charged half of the price for that appointment before I can book another appointment.**

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Level of pressure you prefer?

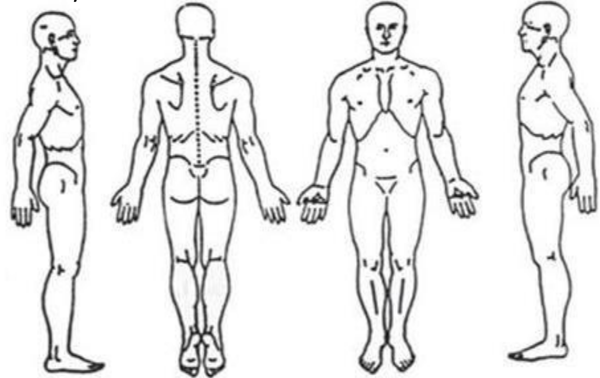
☐ Light ☐ Medium ☐ Deep

Do you have any allergies to nuts/plants/trees/oils? ☐ yes ☐ no

If yes, what: ____

Are there any areas (face, etc.) you do not want massaged?
☐ yes ☐ no
If yes, where: _______________________________________

Circle any areas of discomfort



By signing below you agree to the following.
It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Client Signature __________________________ *Date* __________

Therapist Signature _______________________ *Date* __________