Client Intake Form

Name _____ email: _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell Phone _____

Height: _____ Weight: _____ Birth Date: _____

Profession _____

Referred by _____

Physician's Name _____ Physician's Phone _____

Massage Experience

1. Have you had a professional massage before? . . . . . ❑ Yes ❑ No
2. What types of massage/bodywork have you had? _____

_____

_____

3. How long have you been receiving massage therapy? _____
4. Frequency of treatments? _____
5. What are your goals for treatment? _____

_____

Current Health

6. Do you exercise regularly and/or participate in any sports? . . . . . ❑ Yes ❑ No
If yes, which sports? _____

_____

7. Have you recently suffered an injury? . . . . . ❑ Yes ❑ No
If yes, describe: _____

_____

8. Have you had any areas of inflammation? . . . . . ❑ Yes ❑ No
If yes, describe: _____

_____

9. Are you currently under the care of a physician? . . . . . ❑ Yes ❑ No
If yes, explain: _____

_____

10. Have you had recent surgery? . . . . . ❑ Yes ❑ No
If yes, explain: _____

_____

11. Medications/Allergies: _____

_____

_____

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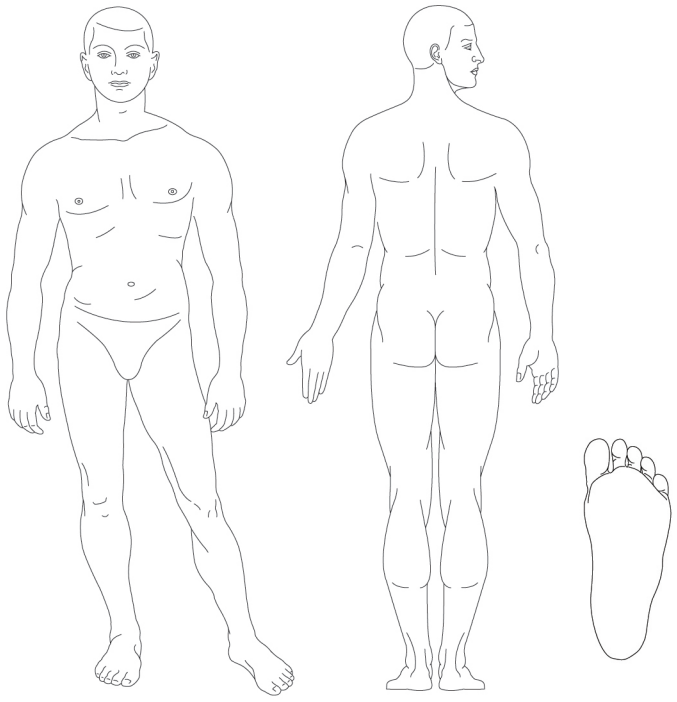
Health History (check one box per item)

	Yes/Current	Past	No
Contact lenses	❑	❑	❑
Dentures	❑	❑	❑
Back pain/Sciatica	❑	❑	❑
Spinal problems	❑	❑	❑
Osteoporosis	❑	❑	❑
Broken bones	❑	❑	❑
Easy bruising	❑	❑	❑
Skin problems	❑	❑	❑
Allergies	❑	❑	❑
Varicose veins	❑	❑	❑
Phlebitis/Blood clots	❑	❑	❑
Heart problems	❑	❑	❑
High blood pressure	❑	❑	❑
Low blood pressure	❑	❑	❑
Ulcer	❑	❑	❑
Tendonitis, bursitis, etc.	❑	❑	❑
Arthritis or joint disease	❑	❑	❑
Diabetes	❑	❑	❑
Seizures/Convulsions	❑	❑	❑
Multiple Sclerosis	❑	❑	❑
Nerve degeneration	❑	❑	❑
Cancer or tumors	❑	❑	❑
Infectious diseases	❑	❑	❑



Any other medical condition(s) the therapist should be aware of? _____

_____

_____

_____

_____

Signature _____ Date _____