

Client Intake Form
Confidential Health Information

Name: _____ Date : _____
Address: _____ City: _____
State: _____ Zip : _____
Phone _____ Email address: _____
Date of Birth: _____ Occupation : _____

Emergency Contact: _____ Phone _____
Referred by: _____

Health History

- Are you currently seeing a medical practitioner?
- If yes, please explain

- Please check if you have any of the following conditions:
__Allergies __Cancer/Tumors __Skin Rash
__Numbness or tingling __Fatigue __Varicose Vein
__Diabetes __High Blood Pressure __Back problems
__Sinus problems __Heart condition __ Contact lenses
__Pregnancy, if so how far along? __Nursing __ TMJ
- Are you taking any medications? If so, please indicate what kind.

- History of injuries, illnesses and /or surgeries
(Please include dates and treatment received)

Massage History/Treatment Information

- Have you ever received a professional massage before?
How often? _____
- What do you do for exercise? _____
- What are your expectations for my massage work?
(ex. relaxation, muscular tension release, etc)

Client Consent:

The massage treatments given here are for the purpose of stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my therapist any time I feel like my well being is being compromised. I understand that massage therapists do not diagnose illness, disease, or any physical or mental

disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I have stated all medical conditions that I am aware of and will update the massage therapist of any changes in my health status.

Client's Signature: _____ Date : _____