Elbe Body - Massage Therapy
Linda E. Moyer, LMT M05285
www.elbebody.com

The Seed House - 860 High Street
Chestertown, MD 21620
512.944.0456

CLIENT INTAKE FORM

Date:________________________ ☐ Male / ☐ Female Date of Birth: ________________________________

Name: ______________________________________ Occupation: __________________________________

Address: ____________________________________ Phone: ______________________________________

City, State, ZIP:______________________________ Email:_______________________________________

➢ What type of health care are you receiving? *(Physicians, chiropractors, homeopaths, acupuncturists, etc.)*

____

➢ Check as relevant below: *(This information is strictly confidential and may be very important to your therapy)*

- ☐ Pregnancy
- ☐ Back or Neck Injuries
- ☐ Fractures
- ☐ Other Bone Trauma
- ☐ Recent Surgery
- ☐ Headaches
- ☐ Contact Lenses
- ☐ High Blood Pressure
- ☐ Dislocations
- ☐ Pulled Muscles
- ☐ Skin Problems
- ☐ Fainting Spells
- ☐ Numbness or Tingling
- ☐ Other ____
- ☐ Diabetes
- ☐ Inflammation
- ☐ Arthritis
- ☐ Asthma
- ☐ Varicose Veins
- ☐ Nausea

➢ Please list and give the years of past surgeries, broken bones, major accidents or serious injuries:

____

➢ Physical Activity/Exercise:

____

➢ Previous massage/bodywork experience: ☐never ☐occasionally ☐often

➢ Are there any areas of tension relevant to this session?

____

➢ Are there any current life stresses relevant to this session?

____

➢ Expectations of this session:

____

➢ Special preference concerning this massage:

____

➢ EMERGENCY CONTACT / PHONE NUMBER:

____

I understand that: massage therapy involves neither diagnosis nor treatment of any condition, and is not a substitute for medical care; this session will consist of Swedish massage, Circulatory Sports Massage, Deep Massage; draping will be used at all times; neither my breast tissue, (female) nor genital areas will be massaged; I may itemize here any areas of my body which I wish to be avoided , and these will be avoided (itemize here if relevant: ____); if I am uncomfortable for any reason I may request the therapist to end the session, and the session will be ended.

Client Signature: ________________________________Therapist Signature:___________________________

CLIENT NAME: DATE:

S	
O	
A	
P	

NOTES: ____

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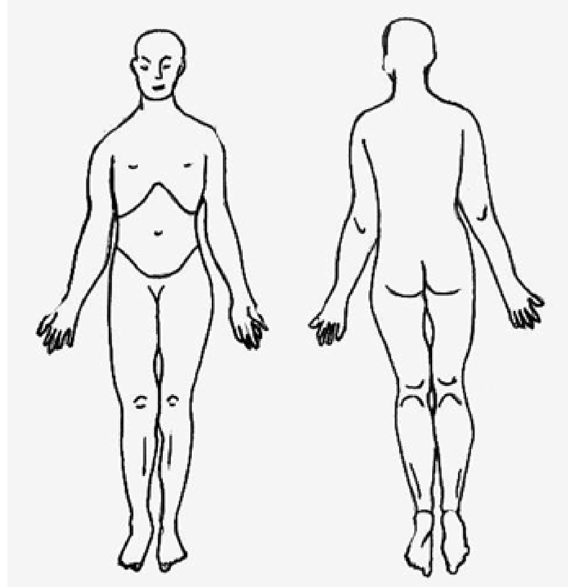

X ADHESION	@ TENDER POINT	INFLAMATION	X ROTATION	/// HYPERTONIC
ρ TRIGGER-POINT	O PAIN	β SPASM	ELEVATION	NO CHANGE

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