



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)*

- | | | |
|--|---|---|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Back or Neck Injuries | <input type="checkbox"/> Dislocations | <input type="checkbox"/> Inflammation |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Pulled Muscles | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Other Bone Trauma | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Recent Surgery | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Other _____ | |

➤ 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.

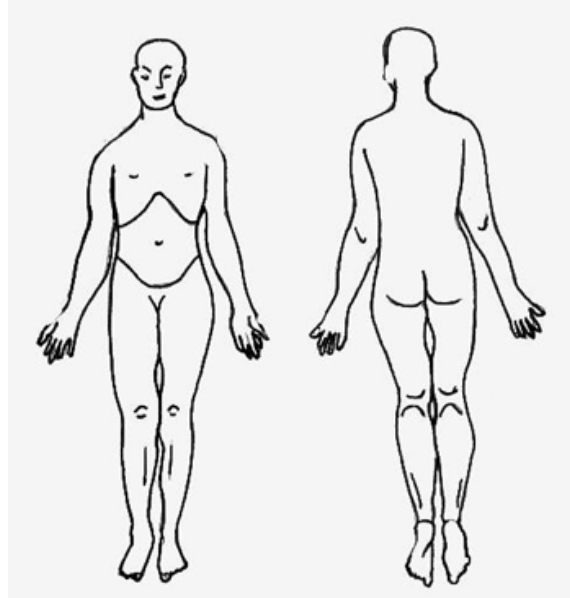
Client Signature: _____ Therapist Signature: _____

CLIENT NAME:

DATE:

S	
O	
A	
P	

NOTES: _____



X ADHESION	@ TENDER POINT	☼ INFLAMMATION	X ROTATION	/// HYPERTONIC
Ⓟ TRIGGER-POINT	O PAIN	β SPASM	↗ ELEVATION	⚡ NO CHANGE

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