Client Intake Form

Name:________________________________ Phone # where you prefer to be reached:________________

Street Address:__________________________________ City, State, Zip:____________________________

Date of Birth:________________ Age:______ Sex: □ M □ F Occupation:____________________

Email address:______________________ Were you referred? □ Y □ N

If yes, by whom:__________________ If no, how did you hear about us?______________________

Have you received a professional massage prior to today? □ Y □ N Reason for this visit:______________

____

Other Health Care Practitioners (HCP) seen for this condition:______________________________

HCP suggested treatment:____________________________ Results: __________________________

When did this condition begin?_________________________ Has it occurred before? □ Yes □ No

____

List all medical conditions (include any surgeries):____

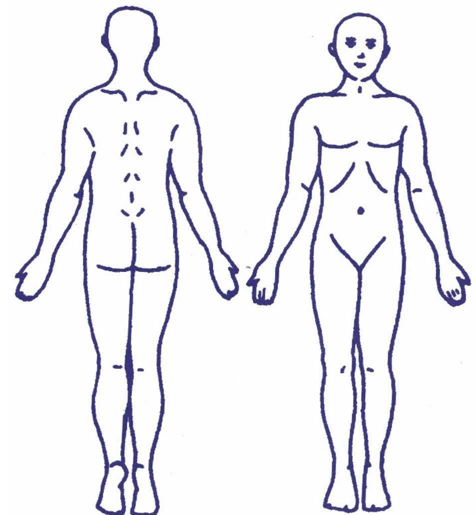
____

List all medications and supplements:____

Please indicate if you have ever experienced any of the following:

□ Arthritis	□ Epilepsy	□ Lyme Disease	□ Heart Disease
□ Cancer	□ Low Back Pain	□ Pain Between Shoulders	□ Neck Pain
□ Joint Pain/Stiffness	□ Fatigue	□ Headaches	□ Heart Problems
□ Lung Problems	□ Varicose Veins	□ Ankle Swelling	□ Poor/Excessive Appetite
□ Hernia	□ Diabetes	□ Arm Pain	□ Blood Pressure Problems
□ Other______________		□ Allergies: Seasonal/Food	□ Chest Pain/Short Breath

Female clients: Are you pregnant? □ Yes □ No



- Sometimes doing work on the body can bring out memories long forgotten or cause emotions to surface unexpectedly. If that happens, please let me know. (please initial) ____________
- The cost for each massage therapy session is the client's responsibility to pay. Payment is expected at time of service. Cancellations: Full payment for services are due if appointment is cancelled less than 24 hours of scheduled time or if missed completely. (please initial) ____________
- I understand that this massage is not a replacement for medical care and that no diagnosis will be made. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in this course of the sessions(s) should be considered as such. (please initial) ____________
- Because massage therapy is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners part, should I forget to do so. (please initial) ____________

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Signature Print name Date