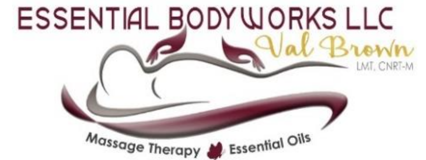
CLIENT INTAKE FORM



Name: ____________________
Address: ____________________
____
Date of Birth: ____________________
Referred by: ____________________

Home Phone: ____________________
Work Phone: ____________________
Cell Phone: ____________________
Emerg. Contact: ____________________
Emerg. Contact's Ph. #: ____________________

CURRENT HEALTH/MEDICAL HISTORY:

	Yes	No	MT use only:
Are you seeing a health care professional?			
Date of last visit:			
Are you taking prescribed medications?			
Are you taking any supplements, herbs, over-the-counter medications or known blood thinners?			
Are you using medical aids today? (contacts, hearing aid, pacemaker, insulin or pain pump, etc.)			

Do you have any of the following? If yes, check the box to the left.

	Cold / Flu		Burns / Sunburn		Headache
	Fever		Numbness / Tingling		Arthritis / Tendonitis
	Infections		Skin Conditions / Warts		Cuts / Bruises
	Contagious Conditions		Digestive Disorders		Depression / Anxiety
	Possible Pregnancy		New tattoos / Piercings		Muscular / Skeletal Disorders

Have you ever been diagnosed with, or been advised to seek treatment for:

	High / Low Blood Pressure		Varicose Veins		Osteopenia / Osteoporosis
	Stroke / TIAs		Bruising Easily		Disk Disorders
	Diabetes / Low Blood Sugar		Lymphatic Conditions		Nerve Disorders
	Heart Disease		Kidney / Bladder Conditions		Seizure Disorders
	Aneurysm		Liver / Gallbladder Conditions		Asthma
	Anemia / Blood Disorders		Cancer / Lymph Nodes Removed?		Chronic Respiratory Conditions
	Phlebitis / Blood Clots		Reproductive System Conditions		Chronic Sinus Conditions

Have you ever had any accidents, injuries, broken or dislocated bones, muscle injuries, hospitalizations or surgeries?

If you answered yes to the above, please explain (give approx. dates) ____________________

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____

____

Any other conditions not mentioned above? ____________________

____

MT use only:

____

____

____

____

What is your occupation? ____

What hobbies, activities or recreation do you participate in? ______________________________

____

____

Massage History:

Have you received professional massage before? ______ If yes, frequency? ______________________

Date of last massage? ___________________________

Why did you choose massage therapy today? ☐ Relaxation only ☐ Relaxation & Treatment for Muscle Issues

Things you like about massage: ____

Things you dislike about massage: ____

Pressure Preference: ☐ Deep ☐ Moderate ☐ Light ☐ Not Sure!

Abdomen Muscles: Some like/need those muscles massaged. You? ☐ Yes ☐ No ☐ Not Sure!

☐ I would like the complimentary biofeedback scan, which will inform me about natural, alternative healthcare choices. Scan results will include essential oils and supplements.

MT Notes:

Please read and sign:

Massage is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. Massage services are designed to be a health aid and is in no way meant to take the place of a physician's care. Information exchanged during a massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand that it is my responsibility to keep the massage therapist updated as to any changes in my medical profile.

I also understand that:

- Any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session with full payment;
- Payment is due when services are rendered, unless other arrangements have been made prior to my appointment;
- I will give 24-hour notice if I cannot keep an appointment.

Signature: _________________________________ Date: ________________________