

Client Intake Form

Name: _____ Date of Birth: ____/____/____
mm / dd / yyyy

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Would you like to receive information regarding future promotions? ___Yes ___No

Would you like to receive quarterly newsletters via email with the latest news and research regarding massage therapy? ___Yes ___No

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Have you ever received massage before? ___ Yes ___ No

If yes, how often do you receive massage? _____

What is your reason for today's visit? _____

What are your desired results of today's session? _____

Please list any medications you are currently taking: _____

Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> abnormal skin condition | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> allergies | <input type="checkbox"/> migraines/headaches |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> cancer | <input type="checkbox"/> pregnant |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> sprains/strains |
| <input type="checkbox"/> depression | <input type="checkbox"/> stress/anxiety |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> tendonitis/bursitis |
| <input type="checkbox"/> digestive abnormalities | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> heart/circulation problems | <input type="checkbox"/> other |

Please explain any of the conditions that you marked above: _____

Please circle your stress level Low 1 2 3 4 5 High

Signature _____

Date _____