CLIENT INTAKE FORM

First Name:

Last Name:

How did you hear about us?

Email Address:

Mobile Phone:

Address:

Emergency Contact Name:

Emergency Contact Relationship:

Emergency Contact Phone:

Date of Birth:

Date of Visit:

Referred By:

Home Phone:

Work Phone:

Preferred Method of Contact ☐ Call ☐ Text ☐ Email

Physician's Name:

Physician's Phone:

How would you rate your general health?

☐ Excellent ☐ Good

☐ Fair ☐ Poor

Have you had a professional massage before?

☐ Yes (Date of last treatment):

☐ No

List current medications & the conditions they are

List any major accidents or surgeries (include dates).

Do you have any allergies or hypersensitivities?

Reason for your visit & areas you want to work on.

PLEASE MARK ANY CONDITIONS THAT APPLY:

Head & Neck

- ☐ Headaches/migraines
- ☐ Vertigo/dizziness
- ☐ Ringing In ears
- ☐ Hearing loss
- ☐ Vision problems
- ☐ Vision loss

Respiratory

- ☐ Asthma
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Frequent colds
- ☐ Smoker
- ☐ Family history of respiratory difficulties

Nervous System

- ☐ Sensory loss/change
- ☐ Numbness/tingling
- ☐ Sciatica
- ☐ Epilepsy
- ☐ Seizures
- ☐ Multiple sclerosis

Musculoskeletal System

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Jaw Pain
- ☐ Family history of arthritis
- ☐ Pins/plates/wires/artificial joints

Reproductive

- ☐ Pregnant
- ☐ Given birth
- ☐ Gynecological problems

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Heart disease
- ☐ Poor circulation
- ☐ Phlebitis/varicose veins
- ☐ Pacemaker
- ☐ Hemophilia
- ☐ Chronic congestive heart failure
- ☐ Family history of cardiovascular problems

Skin & Infections

- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Lyme disease
- ☐ Infectious skin issues

Other Conditions

- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive conditions
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric disorder
- ☐ Unexplained weight loss
- ☐ Other conditions

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It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Signature: Date: