

Client Intake Form

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell Phone _____

Height: _____ Weight: _____ Birth Date: _____

Profession _____

Referred by _____

Physician's Name _____ Physician's Phone _____

Massage Experience

1. Have you had a professional massage before? Yes No

2. What types of massage/bodywork have you had? _____

3. How long have you been receiving massage therapy? _____

4. Frequency of treatments? _____

5. What are your goals for treatment? _____

Current Health

6. Do you exercise regularly and/or participate in any sports? Yes No

If yes, which sports? _____

7. Have you recently suffered an injury? Yes No

If yes, describe: _____

8. Have you had any areas of inflammation? Yes No

If yes, describe: _____

9. Are you currently under the care of a physician? Yes No

If yes, explain: _____

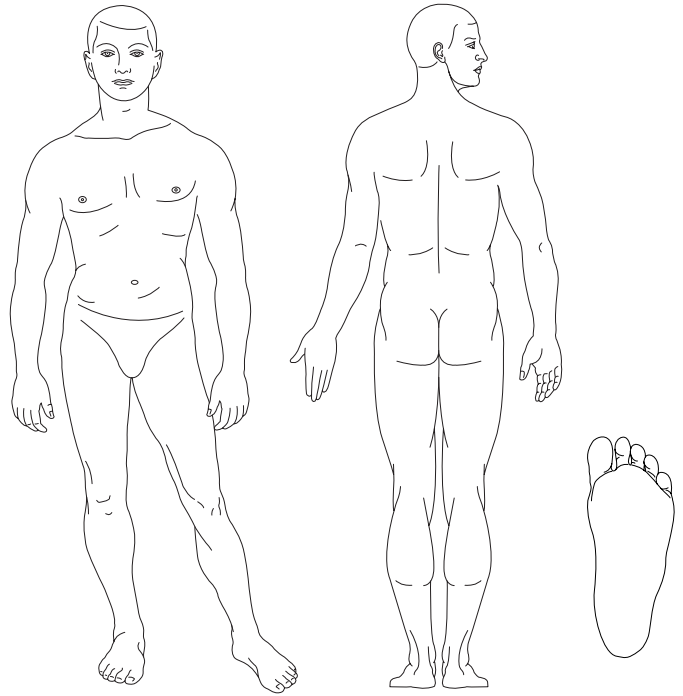
10. Have you had recent surgery? Yes No

If yes, explain: _____

11. Medications/Allergies: _____

Health History (check one box per item)

	Yes/Current	Past	No
Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain/Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis/Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis, bursitis, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or joint disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nerve degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Any other medical condition(s) the therapist should be aware of? _____

Signature _____ Date _____