COUPLES MASSAGE EDUCATION INTAKE FORM

Date: ________________

Partner #1	**Partner #2**
Name: ______________________________________	Name: ______________________________________
Address: _____________________________________	Address: _____________________________________
City: ______________ State: ______ Zip: __________	City: ______________ State: ______ Zip: __________
Phone: ______________________________________	Phone: ______________________________________
Email: ______________________________________	Email: ______________________________________
Date of Birth (Day/Month): ____________________	Date of Birth (Day/Month): ____________________

Would you like e-mail/phone reminders of any future appointments? Yes/No If yes: Email / Phone

How did you hear about me? ____

Are either of you under medical/therapeutic treatment? Yes/No
If yes, for what condition? ____

Specify any known allergies: ____

Is there any chance of a current pregnancy? Yes/No

Check the following conditions that apply to either of you, past and present (and note with your initials which is applicable to each partner. Please add any comments to clarify the condition(s).

Musculo-Skeletal
- Headaches
- Joint stiffness/swelling
- Spasms/Cramps
- Broken/fractured bones
- Strains/sprains
- TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease

Digestive
- Constipation

Skin
- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles

Reproductive System
- Pregnancy:
  - Current Previous
- Menopause
- Miscarriage

Nervous System
- Numbness/Tingling
- Chronic pain
- Spinal cord injury

Circulatory & Respiratory
- High Blood Pressure
- Low Blood Pressure
- Dizziness
- Varicose Veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus conditions
- Asthma

Other
- Depression
- Hearing impaired
- Visually impaired
- Diabetes
- Cancer
- Infectious Disease:

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Please list any additional comments regarding your general health & well-being: ____________________

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We have stated all conditions that we are aware of and this information is true and accurate.
We will inform the health care provider of any changes in our status.

Client's Signature: ____ Date: ________________

Client's Signature: ____ Date: ________________

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Partner #1

1. What would ***you*** like to receive from this session?

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2. What are the "problem" areas that you would most like your partner to be able to address with you at home? Please list in order of preference.

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3. What, if any, barriers have you experienced when trying to assist your partner at home?

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Partner #2

1. What would ***you*** like to receive from this session?

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2. What are the "problem" areas that you would most like your partner to be able to address with you at home? Please list in order of preference.

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3. What, if any, barriers have you experienced when trying to assist your partner at home?

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