CLIENT INTAKE FORM

Date: ________________

Name: ____ Date of Birth (Month/Day): __________

Address: ____ Phone: __________________________

City: ______________ State: _________ Zip: ____________ Email: __________________________

Emergency Contact (Name, Relationship & Phone):____

Would you like to be added to my email mailing list to receive notices of specials? Yes / No

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

How did you hear about me? ____

Are you under medical/therapeutic treatment? Yes/No

If yes, for what condition? ____

Specify any known allergies: ____

Is there any chance you are pregnant? Yes/No Do you like work on your face/scalp? Yes/No

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

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

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:
  ____

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

____

____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform my massage therapist of any changes in my status.

Client's Signature: ____ Date: ________________