Client Intake Form

Name____ Date________________ Date of Birth______________

Phone – Work_________________________ Home________________________ Cell_________________________

Address____ City______________ State_____________ Zip________

Occupation____ Employer____

Work Responsibilities____

Primary Care Provider_______________________________________ Phone_______________________________

Address____ City______________ State_____________ Zip________

Emergency Contact___________________________________ Relationship________________________________

Phone- Work__________________________ Home________________________ Cell_________________________

Current Health

Have you ever received massage therapy before? Yes No

Reason for today's visit: ____

Today's primary concern or goal:_______________________________________ Other:_____________________

List activities affected: ____

Current medications: ____

(Include over-the-counter pain relievers and herbal remedies)

Check any of the following that apply to your current health:

SYSTEMS

- Cardiovascular
- Endocrine
- Gastrointestinal
- Immune
- Musculoskeletal
- Neurological
- Psychological
- Reproductive
- Urinary
- Integument

COMMON CONDITIONS

- Allergies
- Arthritis
- Diabetes
- Hypertension
- Other

SYMPTOMS

- Abnormal energy
- Dietary problems
- Fever
- Headaches
- Inflammation
- Menstrual
- Numbness
- Pain (Where?)
- Pregnancy
- Sleep problems
- Stress
- Swelling

Comments: ____

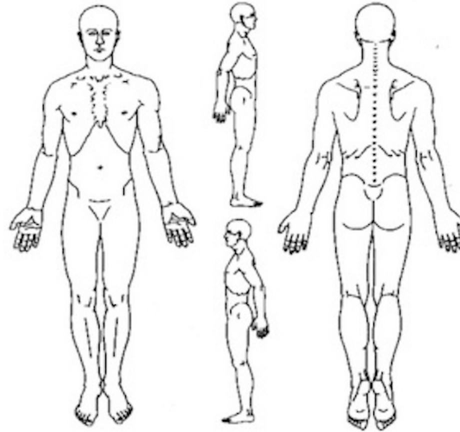
Is there anything I should know to ensure your comfort regarding: _____________________________________

Allergies/sensitivities: oils lotions scents detergents foods animals other: ______________

Contact lenses (the face pillow may put pressure on your eyes): ____

Comments: ____

Mark on Figures all areas of:
Pain, tenderness with O's
Numbness, tingling with ZZ's
Swelling, stiffness with X's
Scars, bruise, open wounds with HH'S
Radial pulse: ____________________



Previous Health History
Surgeries: When and what for? ____

Major accidents: When? ____

Major illness: When and what? ____

Consent for Care
By my signature, I state that I understand that I will receive a therapeutic massage from a License Massage Therapist (LMT). I am aware of the benefits and risk of massage and give my consent for massage. I understand that the LMT is not legally permitted to treat injuries or diseases and that massage should not take the place of a doctor's care when indicated. I have stated all the medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature ____ Date _______________________

Therapist notes: ____

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