

# CLIENT INTAKE FORM

All Information Strictly Confidential

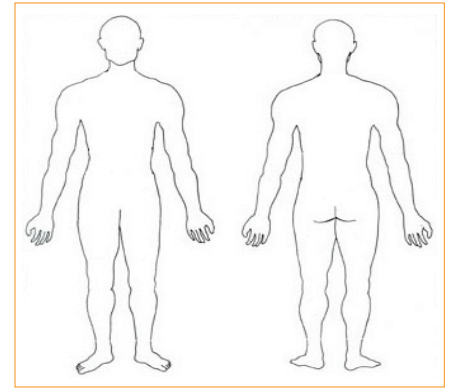
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_  
Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Cell phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Email \_\_\_\_\_

Reminders for appts? **Yes** **No** (please circle one)

Date of Birth \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Referred By \_\_\_\_\_

## Area of Pain

Please note on the bodies to the right where you are feeling pain or discomfort.



## Medical Conditions and ALL Current Medications

If you currently have or have had any of the following medical conditions or incidents, please indicate type of condition if necessary and year of occurrence. Some medical conditions and medications may be contraindicated by massage.

Cancer (type) \_\_\_\_\_ Stroke \_\_\_\_\_  
Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_  
Heart Attack or Disease \_\_\_\_\_ HIV/AIDS \_\_\_\_\_  
Pregnancy \_\_\_\_\_ Fibromyalgia \_\_\_\_\_  
Migraine or tension headaches \_\_\_\_\_ Phlebitis \_\_\_\_\_  
Osteo- or Rheumatoid Arthritis \_\_\_\_\_  
Surgery (type) \_\_\_\_\_

Have you ever had a professional therapeutic massage? **Yes** **No**  
If yes, what type (Swedish, Deep Tissue, Cranial Sacral, etc.) \_\_\_\_\_

Are there areas that you do not like to have worked? \_\_\_\_\_

Are you allergic or sensitive to aromatherapy or nut oils? **Yes** **No**

Are you sensitive to heat or cold? **Heat** **Cold** **Both** **No**

Do you have any recent injuries? \_\_\_\_\_

Medications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional comments? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr. Name \_\_\_\_\_

Dr. Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Your health and wellness is the goal for each session and your treatments are opportunities to facilitate health and healing in your life. The services of the therapist are not a substitute for professional medical care. If needed, permission is granted for the therapist to contact your doctor regarding your sessions for your health and safety. The therapist is not liable for injury or adverse effects due to an incomplete medical history given on this intake form. Please communicate openly during your massage regarding pressure and areas of attention so that your session can best suit your needs. In consideration of the therapist's schedule and time of other clients, please kindly give 24 hours advanced notice of cancellation. No-show appointments will be charged for the full session missed, and a cancellation fee of \$25 may be charged in the event of a same-day cancellation. I have read and understand the cancellation policy.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_