Client Intake Form

Date of Initial Visit: _____

Name: _____ Date of Birth: _____

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____Email: _____

Primary Physician: _____Physician Phone: _____

Occupation: _____Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____Phone: _____

Medical Information

Reason for initial visit: _____

_____

Height & Weight: _____

Are you currently pregnant? ☐ Yes ☐ No

Any high risk factors? _____

Are you taking any medications?

If yes, please list name and use: _____

_____

Do you have any allergies? ☐ Yes ☐ No

If yes, please list known allergies _____

_____

Are you experiencing any discomfort, pain, tension or stiffness?
☐ Yes ☐ No If yes, please explain _____

_____

Do you perform repetitive movements in your everyday activity? ☐ Yes ☐ No If yes, please explain _____

_____

Have you recently had any injuries, areas of inflammation or surgeries? ☐ Yes ☐ No If yes, please explain _____

_____

Do you experience stress in aspects of your life? ☐ Yes ☐ No
If yes, please explain _____

_____

Please list all forms and frequency of stress reduction activities, hobbies, exercise, or sports participation

_____

Do you sit for long hours while driving or at a computer workstation? ☐ Yes ☐ No If yes, please explain

_____

Health History

☐ Fatigue
☐ Tension, stress
☐ Sleep difficulties
☐ Chronic pain
☐ Headaches, migraines
☐ Vision problems
☐ Hearing problems
☐ Shingles
☐ Pinched Nerve
☐ Parkinson's disease
☐ Multiple Sclerosis
☐ Shingles
☐ Numbness/Tingling
☐ Paralysis
☐ Ovarian/Menstrual Problems
☐ Prostate issues
☐ Sinus Problems
☐ High/Low Blood Pressure
☐ Diabetes
☐ Joint Replacement(s)
☐ Neuropathy
☐ Sprains or Strains
☐ Heart Attack
☐ Heart Conditions
☐ Stroke
☐ Fibromyalgia
☐ Stroke
☐ Kidney Dysfunction

☐ Blood Clots
☐ Arthritis
☐ Jaw Pain (TMJ)
☐ Lupus
☐ Bone or Joint Disease
☐ Spinal Problems
☐ Phlebitis/Varicose Veins
☐ Thrombosis/Embolism
☐ Blood Clots
☐ Lymphedema
☐ Breathing Difficulty/Asthma
☐ Allergies
☐ Rashes
☐ Fatigue
☐ Colitis
☐ Cosmetic Surgery
☐ Athletes Foot
☐ Herpes/ Cold Sores
☐ Depressions
☐ Anxiety/Stress Issues
☐ Drug/Alcohol/Tobacco Use
☐ Dentures
☐ Hearing Aids

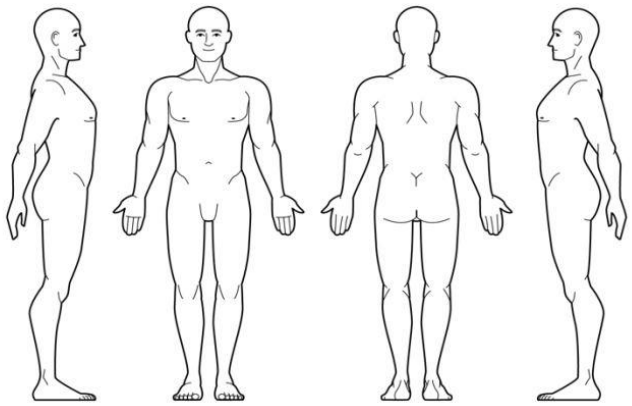
Any other medical condition(s) not listed:

_____

_____

_____

Please circle any areas of discomfort.



Massage Information

Have you had a professional massage before? ☐ Yes ☐ No

How long have you been receiving massage therapy? _____

_____

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No If yes, please explain_____

_____

What are your goals for this treatment? _____

_____

_____

Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that the Federation of State Massage Therapy Boards has provided this form as a reference and is not held liable for any services provided.

Signature: _____ Date: _____