Client Intake Form

Name ______________________________ Date of Birth ____________________

Street Address/Apt Number ____

City________________ State_____ Zip________ Contact Phone Number______________________

E-mail______________________________ Emergency Contact ____________________________

Occupation/employer ____

Medical History and Information

Check any or all that apply to your present health:

___ Headaches ___Chronic Pain ___Varicose Veins

___ Vision Problems ___Muscle or Joint Pain ___Blood Clots

___ Sinus Problems ___Numbness/Tingling ___High/Low Blood Pressure

___ Jaw Pain/Teeth Grinding ___Sprains/strains ___Diabetes

___ Fatigue ___Scoliosis ___Cancer/Tumors

___ Depression ___Arthritis ___Infectious Disease

___ Sleep Difficulties ___Tendonitis ___Skin Problems

Women only: ___Pregnant ___Painful Menstruation ___Endometriosis

Men only: ___Prostrate Problems

List all medications/herbs/vitamins and dosage: ______________________________________

____

List physical activities you participate in regularly_________________________________

What movements or activities are limited? ____________________________________

Describe the events of the injury or accident: __________________________________

____

____

List previous major injuries/surgeries: ______________________________________

____

What other treatments are you receiving and by whom (acupuncture, physical therapy, chiropractic, naturopathic): ____

____

What seems to help the most? ____

What seems to aggravate the condition the most?____

What is your main activity at work? On phone ________ Sitting________ Computer work____________

Driving car_____________ Walking_____________ Other _______________________________________

What do you do to relieve stress?____

What do you want to get out of your session(s)?____

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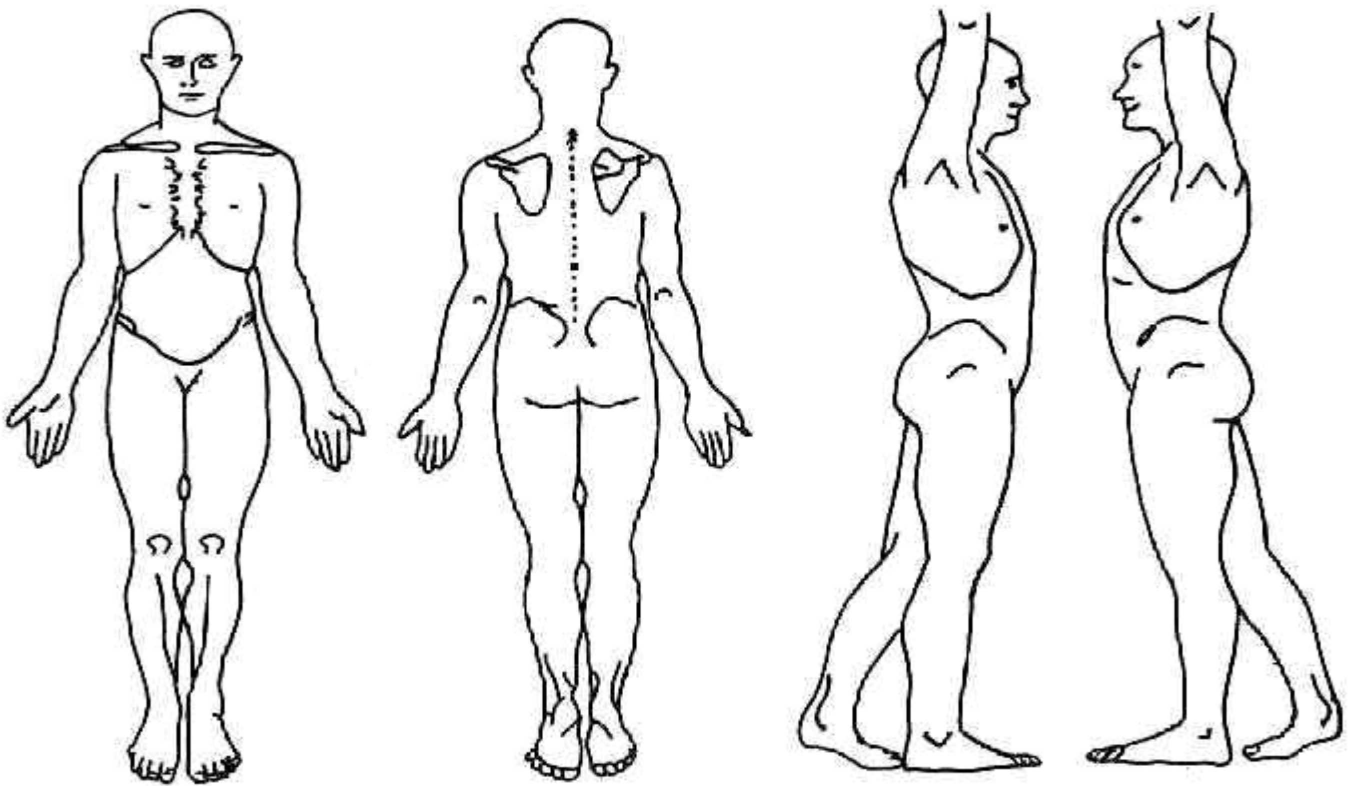
____

Please put an x on the areas of discomfort.



_____I agree I am responsible for all charges for all services provided. I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.
I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Signature _______________________________________ Date ____________________________________

- **It is very important to drink plenty of water after each massage**.