

# Client Intake Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Alternative Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

How do you prefer to be addressed? \_\_\_\_\_ How did you hear about me? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Have you had a professional massage before? \_\_\_\_\_ How often: \_\_\_\_\_ Type: \_\_\_\_\_

Do you wear Contacts? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Are you currently under a doctor's care? \_\_\_\_\_ Please explain: \_\_\_\_\_

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**Do you have a history of the following? Please check if "yes".**

**Musculoskeletal:**

- \_\_\_ Bone or joint disease
- \_\_\_ Arthritis
- \_\_\_ Sprains/Strains
- \_\_\_ Low back pain
- \_\_\_ Mid/Upper back pain
- \_\_\_ Hip/Leg pain
- \_\_\_ Neck pain
- \_\_\_ Shoulder/Arm pain
- \_\_\_ Headaches
- \_\_\_ Jaw pain/Clicking/Popping
- \_\_\_ Clenching or Grinding teeth
- \_\_\_ Spasms/Cramps
- \_\_\_ Spinal Curvature
- \_\_\_ Fibromyalgia
- \_\_\_ Other \_\_\_\_\_

**Digestive:**

- \_\_\_ Constipation
- \_\_\_ Gas/Bloating
- \_\_\_ Hiatal hernia
- \_\_\_ Other \_\_\_\_\_

**Neurological:**

- \_\_\_ Herpes/Shingles
- \_\_\_ Numbness/Tingling
- \_\_\_ Chronic Pain
- \_\_\_ Dizziness (any cause)
- \_\_\_ Other \_\_\_\_\_

**Genitourinary:**

- \_\_\_ Kidney Infections
- \_\_\_ Kidney Stones
- \_\_\_ Prostate Problems
- \_\_\_ Other \_\_\_\_\_

**For Women Only:**

- \_\_\_ Painful Menstruation
  - \_\_\_ Yeast Infections
  - \_\_\_ Breast lumps/masses
  - \_\_\_ Other \_\_\_\_\_
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**Respiratory/Circulatory:**

- High blood pressure
- Breathing difficulties
- Varicose veins
- Other cardiovascular problems
- Other \_\_\_\_\_

**Other:**

- Allergies (any)
- Cancer/tumors
- Sinus problems
- Fatigue
- Difficulty Sleeping
- Diabetes
- Drug/Alcohol addiction
- Other \_\_\_\_\_

**Infectious Disease:**  Disease name(s) \_\_\_\_\_

**Nicotine/caffeine use:** \_\_\_\_\_

**Lymph Node Removal:** \_\_\_\_\_ If yes, location: \_\_\_\_\_

**Skin:**

Rashes  Bruise easily  Sensitive skin  Hives/allergies  Other \_\_\_\_\_

Are you taking any prescription or over the counter medications? \_\_\_\_\_

Illnesses: \_\_\_\_\_

Injuries: \_\_\_\_\_

Surgeries: \_\_\_\_\_

In Case of Emergency, Please Notify: Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Payment will be:  Check  Cash  Gift Certificate  Credit Card (\$5 processing fee applies)

I understand that a block of time has been set aside for my treatment and requires me to give no less than 12 hours notification for cancellation; failure to do so could result in a fee or prepayment for my next treatment.

\_\_\_\_\_

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical, chiropractic treatment or pharmaceuticals. It is in no way intended to be a substitute for professional health care. I have stated all medical conditions of which I am aware, and will update the therapist of any changes in my health status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

