Client Intake Form   Today's Date ________________

Name____ Date of Birth___________

Mailing Address____

City____________________________ State________________ Zip___________

Phone Number Home:________________________ Cell:____________________

Work Phone:___________________ Email:_______________________________

Occupation_________________________ Referred by____________________

Have you ever experienced a professional massage/bodywork session?____________
What are your massage expectations/goals?______________________________
What kind of pressure do you prefer? Light Medium Firm Deep Tissue
Do you have any limited range of motion? Explain_______________________
Is there any area you prefer not massaged? (abdomen, glutes, feet, etc.)__________
Allergies (aromas/essential oils/shellfish/nuts, etc.)_____________________
Do you currently see a chiropractic physician? ___________________________
Do you have medical insurance? ______________________________________

Check all that apply:

____Arthritis	____Pregnant	____Stress	____Diabetes
____Epilepsy	____Bursitis	____Cancer	____Contact Lenses
____TMJ Disorder	____Edema	____Contagious Disease	____Foot Problems
____Heart Problems	____Sinuses	____Joint Pain	____Osteoporosis
____Low Back Pain	____Sciatica	____Varicose Veins	____Numbness
____Bruise Easily	____Migraines	____High Blood Pressure	____Fibromyalgia
____Skin Disorders	____Lupus	____Multiple Sclerosis	____Depression
____Breathing Problems	____Dentures	____Kidney Problems	____Pacemaker

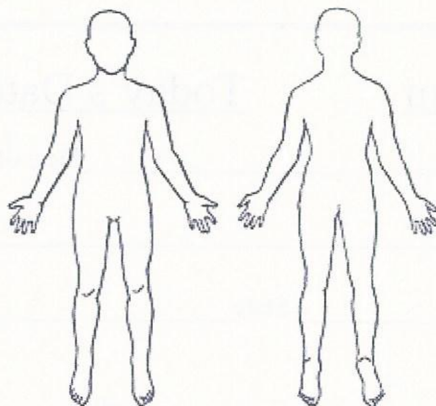
Have you had any injuries within the last 72 hours? Please explain__________________

Do you experience frequent or constant pain?________________________________

Are you taking any medications?____________________________________

Have you ever had surgery?_______________________________________

Please indicate below where you are feeling any discomfort



INFORMED CONSENT: Please take a moment to read the following:

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Massage is contraindicated for some serious medical conditions. It may be necessary to obtain a doctor's release or prescription before beginning therapy. I agree to inform the therapist of any experience of pain during the session. Also, it is my responsibility to keep my massage practitioner informed of any changes in my health and any medications that I may begin to take in the future. I understand that I will be properly draped at all times except the area being worked, and that the massage is not sexually oriented in any way. Any illicit or suggestive remarks or behavior on my part will result in immediate termination of the session with full payment expected. I give my consent to receive the treatment discussed in this and all future sessions. I agree that my presence at subsequent sessions shall be construed to be validation of this written consent. 48-hour notice of cancellation is required. No shows and late arrivals will be charged the amount of the full session and will not receive an extension of scheduled service time. If you are uncomfortable with ANYTHING at ANY TIME, please inform your therapist.

Signature____ Date______________