Client Intake Form

date of visit:___________________________

Personal Information

____
name DOB

____
address

____
city state zip

____
home phone cell

____
email

____
occupation

____

____
referred by

____
emergency contact (relationship) phone

Massage Experience

Have you had a personal message before? **Yes** **No**

If Yes, what type? (Swedish / shiatsu / deep tissue)

____

For how long?________________________________

Frequency___________________________________

Your goals for treatment: ______________________

____

Current Health

Reason for Visit________________________________

____

____

Exercise / Sports? **Yes** **No**

If yes, what exercise / sports?_____________________

____

Describe any repetitive movements?

____

____

Do you sit for long hours (workstation / computer / car)

Describe_____________________________________

____

Stress at work / family / other **Yes** **No**

Describe_____________________________________

____

Are you experiencing tension, stiffness or pain? **Yes** **No**

If yes, describe_________________________________

____

Recent Injury, surgery or inflammation? **Yes** **No**

If yes, describe_________________________________

Sensitive skin? **Yes** **No**

Medications:___________________________________

Health History

Musculoskeletal
__Bone or Joint Disease
__Tendonitis /Bursitis
__Arthritis / Gout
__Jaw Pain (TMJ)
__Lupus
__Spinal Problems
__Migraines / Headaches
__Osteoporosis

Circulatory
__Heart Condition
__Phlebitis / Varicose Veins
__Blood clots
__Low/High Blood Pressure
__Lyphedema
__Thrombosis/Embolism

Respiratory
__Breathing / Asthma
__Emphysema
__Allergies (specify)
__Sinus problems

Nervous System
__Shingles
__Numbness/Tingling
__Pinched Nerve
__Chronic Pain
__Paralysis
__Multiple Sclerosis
__Parkinson's Disease

Psychological
__Anxiety / Stress
__Depression

Skin
__Allergies (Specify)
____
__Rashes
__Cosmetic Surgery
__Athlete's Foot
__Herpes/Cold Sores

Digestive
__Irritable Bowel Syndrome
__Bladder/Kidney Ailment
__Colitis
__Crohn's Disease
__Ulcers

Other
__Cancer/Tumors
__Diabetes
__Drug/Alcohol/Tobacco
__Contact Lenses
__Dentures
__Hearing Aides
__Other (specify)
____

Reproductive
__Pregnant (stage____)
__Ovarian/Menstrual
__Prostrate

SIGNATURE____DATE:___________________