Client Intake Form

Personal Information:

Name _____ Phone (____) _____ DOB_____

Address_____ City_____ State_____ Zip_____

Email _____ Referred by_____

Occupation_____

Emergency Contact_____Phone_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? Yes No

How often would you like to receive massage?
Once per week( ) Once per month( ) Every other month( ) Several times a year( )

Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain

Do you have any allergies to oils, lotions, or ointments? Yes No

Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think it has affected your health?
(Please check all that apply)

muscle tension( )	anxiety( )
depression( )	insomnia( )
irritability( )	other( )

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes

Do you have any particular goals for this massage session? Yes No
If yes, please explain

What would you like to manifest in your life that you do not currently have or would like more of?

Medical History

11. Are you currently under medical supervision? Yes No
If yes, please explain

12. Are you interested in seeing a chiropractor? Yes No

13. Are you interested in learning self-massage/foam rolling techniques? Yes No

14. Are you currently taking any medication? Yes No If Yes, please list

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

I,_____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Practitioner _____ Date _____