Client Intake Form

Date

Please fill out all of the information as accurately and thoroughly as possible.

Name: _____ Date of Birth: _____

Address: _____

Work Phone :( ) _____ - _____ Home Phone: ( ) _____-_____ Cell Phone ( ) _____-_____

Email: _____

Referred by: _____

Do you exercise? _____ Frequency: _____

Please describe what type of excersice_____

Other daily activities: _____

Primary Care Physician/Telephone Number: _____

Chiropractor/Telephone Number: _____

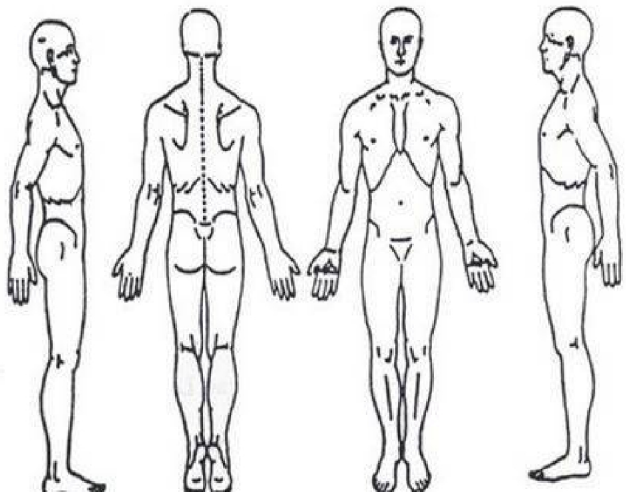
May I contact your primary physician or chiropractor? Yes ◯ No ◯

Are you currently taking any medication(s)? _____

List any medications that you took today: _____

How do you relieve stress or pain? _____

Are you currently suffering from any pain related to traumatic experience or areas of discomfort (i.e. car accidents, sports injuries, Surgeries, illness, tension areas).____ Please indicate on the diagram below.



Have you ever received a professional massage or body work before? If so how was it?

How would you like to feel after the massage? _____

Are there any areas that you prefer **NOT** to have worked on (i.e. face, scalp, feet, abdomen)?

Do you have any of the following conditions? (Place in "X" in the box for all that apply)

	Neck Pain		**High Blood Pressure**		**Fibromyalgia**		**Headaches**
	Back Pain		**Varicose Veins**		**Currently Pregnant**		**Diabetes**
	Skin Condition		**Heart Condition**		**Allergies**		**Asthma**
	TMJ (Jaw Pain)		**Carpal Tunnel**		**Arthritis**		**Seizure Disorders**
	Tendonitis/Bursitis		**Blood Clots**		**Stroke**		**Sciatica**
	Bruise Easily		**Malignant Cancer or Tumors**		**Benign Cancer or Tumors**		**Fatigue**
	Flu		**Common Cold**		**Osteoporosis**		**Scoliosis**
	Broken Bones		**Pulled Muscle**		**Numbness**		**Stiff or Painful Joints**

Is there anything else that I need to know before we start the session?

I have completed this client intake form to the best of my knowledge. I understand the massage services are designed to be a health aid and in no way substitute a physician's care when indicated. I understand massage practitioners are not qualified to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness. If I experience any pain or discomfort during the massage, I will immediately inform the practitioner so that pressure/stroke may be adjusted to my comfort. I agree to keep the practitioner updated as to any changes in my medical profile and I understand there shall be no liability on the practitioner's part if I fail to do so. A 24 hour cancellation notice is required or you will be charged $40.00

Parent/Guardian (*if under 18 years of age) Signature _____Date_____

Signature_____ Date_____

*If the client that will be having body work done is under 18 years of age **their parent/guardian** must be present during the entire session.