



CLIENT INTAKE FORM



_____ name

_____ phone _____ date of birth

_____ address _____ city _____ state _____ zip

_____ in case of emergency contact _____ referred by

- Yes No Do you frequently suffer from stress? Yes No Have you had any broken bones in the last two years?
- Yes No Do you have diabetes? Yes No Have you had any surgery in the last two years?
- Yes No Do you experience frequent headaches? Yes No Do you have pain or soreness in a specific area?
- Yes No Are you pregnant? Yes No Do you have cardiac or circulation problems?
- Yes No Do you have arthritis? Yes No Do you have back pain?
- Yes No Are you wearing contact lenses? Yes No Are you sensitive to touch or pressure in any area?
- Yes No Do you have high blood pressure? Yes No Do you have any other medical conditions or any medications I should know about?
- Yes No If 'Yes', are you taking medication for it?
- Yes No Do you have varicose veins? Yes No Do you have any contagious diseases?
- Yes No Do you have any skin conditions? Yes No Do you have any allergies?
- Yes No

If you answered 'Yes' to any questions, please provide details below:

*Please take a moment to read and understand the following.
Then please sign and date below. Thank you!*

I understand that the massage I will receive today is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other licensed medical professional for any ailment I am aware of. I understand that the massage therapist is not qualified to diagnose, prescribe for, or treat any ailment or illness and nothing said in the course of the session should be construed as such. Massage should not be performed under certain medical conditions, and I affirm that I have stated all my known medical conditions, and answered all questions honestly.

I agree there shall be no liability on the practitioner's part if I fail to do so.

_____ client

_____ date

_____ therapist

_____ date