

Client Intake Form

Date: ___/___/___ Name: _____ Date of Birth: ___/___/___
 Mailing address: _____
 Employer: _____ Occupation: _____
 Contact numbers: Home: (____)____-____ Work: (____)____-____
 Fax: (____)____-____ Voice mail: (____)____-____ E-mail: _____
 Emergency name and phone number: _____

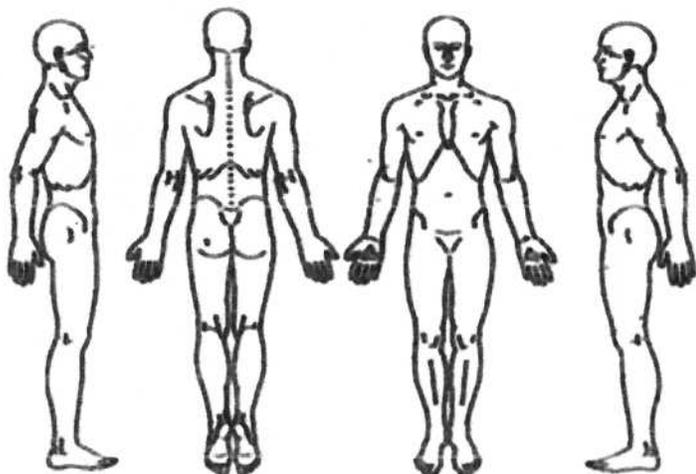
Health Data

Allergies: _____ Reason for visit: _____
 Have you had a massage before? ___ Yes ___ No If yes, what kind of massage? _____
 Any injuries within the past 72 hours? ___ Yes ___ No Explain _____

Check all that apply:

- breathing problems (lung)
- bruise easily
- carpal tunnel
- contact lenses
- diabetes
- exercise
- heart problems
- high blood pressure
- medications
- migraines
- pregnant
- psychotherapy
- sciatica
- sinuses
- suffer from stress
- TMJ (jaw pain)
- last consumption of alcohol _____

Mark appropriate stress zones:



Informed consent: The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I understand this does not deter me from seeking medical treatment for medical conditions I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will automatically end the session.

I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so. I agree to hold harmless the establishment, all management, including volunteers, from and against any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims, etc., are groundless, false, and fraudulent.

Signature

Date