Generations Massages

Client Intake Form

PLEASE PRINT LEGIBLY

Name_____Email_____

Address_____

City_____State_____Zip_____

Phone: Main_____Cell_____Birthday____/____/_____

Occupation_____ Referred by_____

In Case of Emergency Please contact_____ Phone_____

General and Medical Information

Y N Have you ever had a professional massage? If yes how often?

_____

Y N Are you pregnant? If yes, how far along are you? _____

_____

Y N Are you sensitive to touch/pressure in any area?

_____

Y N Are you allergic or sensitive to any oils or scents? If yes, please list:

_____

List of current medications and reason:

_____

_____

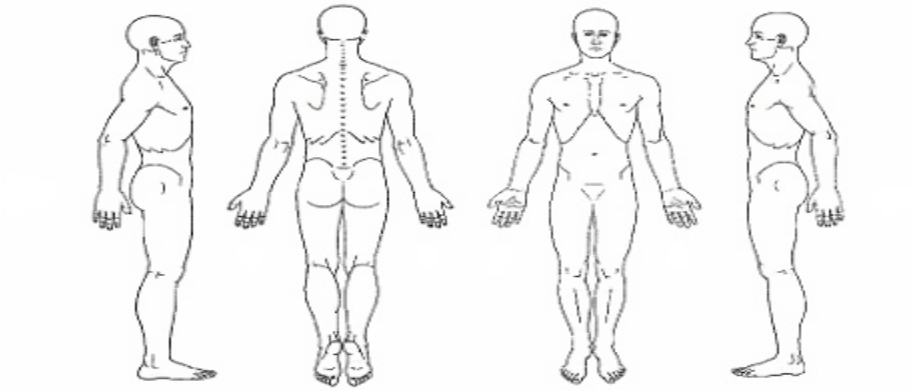
List of surgeries (type and date:

_____

_____

On a scale from 1 to 10, 10=highest, rate your levels of: Stress ____ Pain____ Energy____
How did your symptoms begin and when did they start?
_____

Please Indicate Areas of Pain/Tension:



What have you done for relief? _____

Is it getting better/worse? _____

Please check all that apply

0 Skin condition-rash, warts hives, skin cancer, other_____

0 Lymphatic condition-swollen gland, nasal congestion, lymph edema

0 Joint problems/stiffness-arthritis, sacroiliac problems, TMJ, other_____

0 Bone condition-osteoporosis, fracture, other_____

0 Headaches/ migraines

0 Recent injury or accident-whiplash, sprain, bruise, other_____

0 Circulatory condition-high blood pressure, varicose veins, blood clots

0 Numbness/Tingling, sciatica

0 Tendonitis, bursitis

0 Diabetes