Cypris Bodywork & Wellness

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Client Intake Form

Name (First, Last) ________________________________ Preferred Pronouns_____________

Phone (day)_______________ Phone (Night)___________ Email________________________

Address City/State/Zip____

Date of Birth________________ Height______ Wieght______Occupation_________________

What Brings You In Today?____

____

1. Have you had a professional massage before?______________________________________

   If yes, how often do you receive massage therapy?_______________________________

2. Do you have any difficulty lying on your front, back, or side?

   If yes, please explain____

3. Do you have any sensitivity to oils, lotions, ointments or smells?________________________

   If yes, please explain____

4. Do you have sensitive skin?____

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation ( ) computer ( ) driving ( )?

7. Do you perform any repetitive movement in your work, sports, or hobby?_______________

   If yes, please describe____

8. What place in your body do you normally hold stress?________________________________

9. What goals do you have for this massage session?____________________________________

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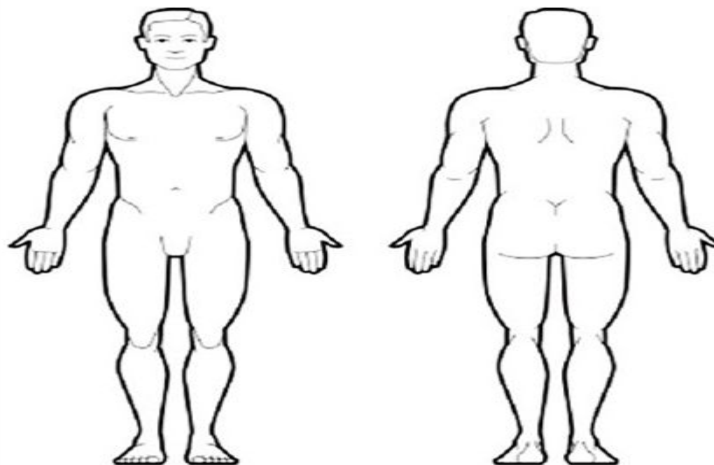
Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

Do you have a history of any of the following conditions? If yes, please check and describe details below.

	Condition		Condition		Condition		Condition
	Bone/Joint Disease		Lupus		Varicose Veins		Emphysema
	Arthritis		Multiple Sclerosis		Blood Clots		Shingles
	Tendonitis/Bursitis		Spinal Problems		High/Low Blood Pressure		Numbness/Tingling
	Gout		Migraine/Headache		Thrombosis/Embolism		Pinched Nerve
	Jaw Pain (TMJ)		Osteoporosis		Asthma		Chronic Pain
	Paralysis		Parkinson’s Disease		Currently Pregnant		Menstrual Problem
	Ovarian Problem		Prostate Problem		Skin Allergy		Surgery
	STD’s		IBS (Irritable Bowel)		Crohn’s Disease		Ulcers
	Anxiety		Depresion		Diabetes		Cancer/Tumors
	Epilepsy		Insomnia		Sciatica		Sprain/Strain

Medical History Details

Please describe any condition that was not listed above as well as describing any condition you checked yes:

Details:____
____
____
____
____
____

Are you currently taking any medications?
If yes, please list here:____
____
____
____

Do you have any allergies? If yes, please
list____