

## Client Intake Form

Name (First, Last) \_\_\_\_\_ Preferred Pronouns \_\_\_\_\_

Phone (day) \_\_\_\_\_ Phone (Night) \_\_\_\_\_ Email \_\_\_\_\_

Address City/State/Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ 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 ( )?

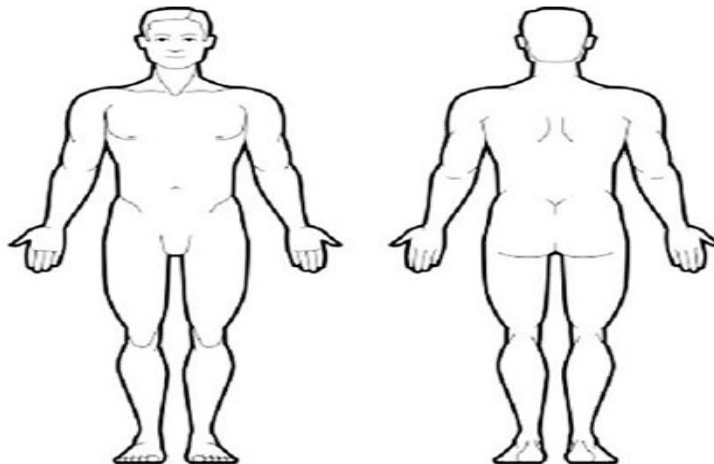
7. Do you perform any repetitive movement in your work, sports, or hobby? \_\_\_\_\_

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? \_\_\_\_\_

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.

	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		Depression		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 \_\_\_\_\_

# *Cypris Bodywork & Wellness*

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