Client Intake Information Form

Name_____Date_____

Address_____City_____State_____Zip_____

Phone(Day)_____(Eve)_____Date of Birth_____

Email Address(Your information will not be shared)_____

Occupation_____Employer_____

Referred By_____Physician_____

Previous experience with Massage Therapy_____

Primary reason for appointment/areas of pain and tension

_____

Emergency Contact(Name and Number)_____

Please mark(X) for all the conditions that apply now. Put a (P) for past conditions, and an (F) for Family history of illness.

Pain Scale: minor- 1 2 3 4 5 6 7 8 9 severe- 10

___headaches, migraines	___chronic pain	___fatigue
___vision problems, contact lenses	___muscle or joint pain	___tension, stress
___hearing problems, deafness	___muscle, bone injuries	___depression
___injuries to face or head	___numbness or tingling	___sleep difficulties
___sinus problems	___sprains, strains	___allergies, sensitivities
___dental bridges, braces	___arthritis, tendonitis	___rashes, athletes foot
___jaw pain, TMJ problems	___cancer, tumors	___infectious diseases
___asthma, respiratory conditions	___spinal column disorders	___blood clots
___constipation, diarrhea	___diabetes	___varicose veins
___hernia	___pregnancy	___high blood pressure
___heart, circulatory conditions	___abdominal or digestive conditions	___other, please explain

Explain any areas indicated above

_____

Medications/Surgeries/Accidents

_____