Client Intake Form

Please print clearly.

Date:_____

Name:_____
First Last

Date of Birth:_____/_____/_____ **Marital Status**:_____

Occupation:_____ **Date of Last Massage**:_____

Mailing Address:_____

City:_____**State**:_____**Zip**:_____

Home Phone:_____ **Cell**:_____

Email:_____

Primary Health Care Provider:_____

Permission to Consult with Primary Provider? (Y/N)_____If yes, please initial: _____

Are you currently under other practitioners' care? Acupuncturist Chiropractor Herbalist Nutritionist Physical Therapist Counselor/Therapist Other:_____

Referred by (please circle): Card Friend/Family Website Google Other:_____

Purpose for massage (circle): Promote Health Relaxation Rehabilitation Stress Relief Pain Relief

Do you suffer from frequent headaches? (Y/N)_____

Do you have allergies to lavender/lanolin/anything?:_____

Please list all medications & supplements you are currently taking:_____

_____

Please list any cardiovascular/circulation issues you may have:_____

_____

Please list all other surgeries/conditions/accidents:_____

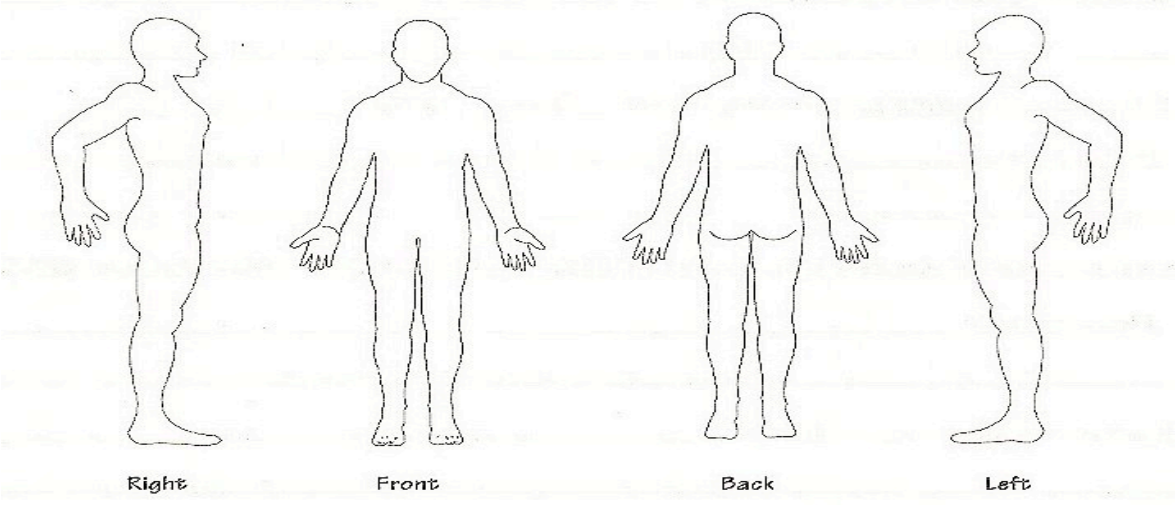
_____

_____

_____

If you are pregnant, how many weeks along now?_____

Please indicate areas of tension or pain in your body on the diagrams below:



Comments:_____