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:__________________ **Work Phone**:_____________________**Ext.**_________

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): Sign Card Friend/Family Flyer 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/concerns:________________________________

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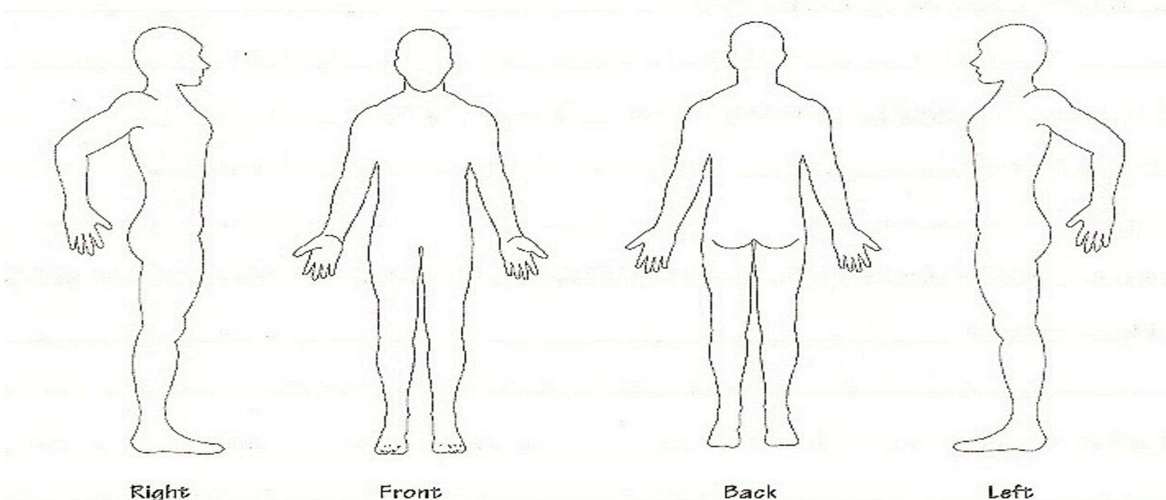
____

____

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

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



Comments:____