Blissful Massage Therapy Client Intake Form

Date:_____

Please print clearly.

Name:_____ Gender:_____
First Last

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

Occupation:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Primary Phone #:_____ Second Contact #:_____

Email:_____

Emergency Contact:_____Phone:_____

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

Referred by: Card Friend/Family Website Google Other:_____

Goal for massage: Promote Health Relaxation Rehabilitation Stress Relief Pain Relief

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

Do you like aromatherapy? Any specific scents you can't stand?_____

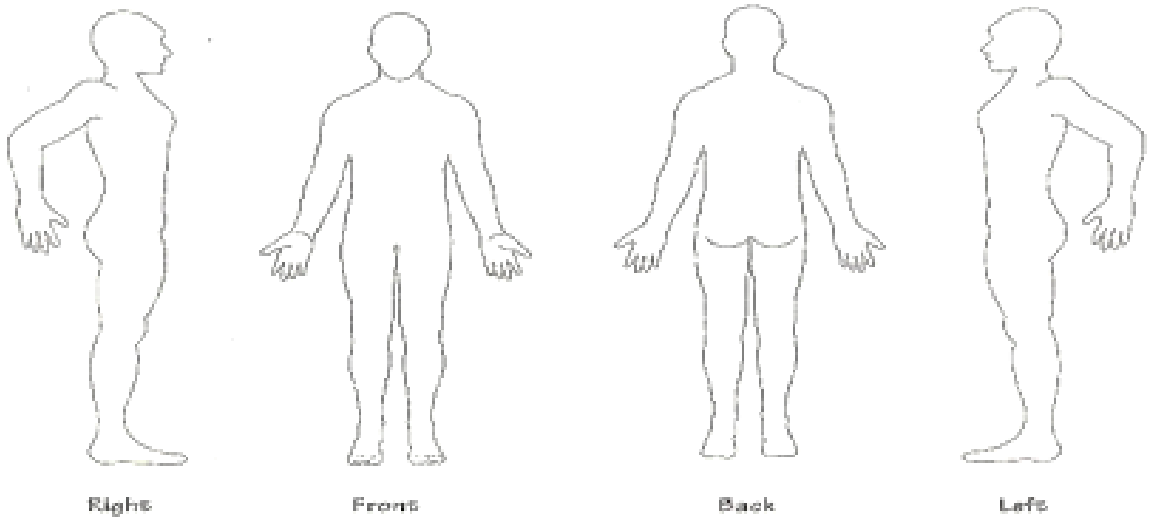
If you are pregnant, how many weeks along now?_____

List any medications or supplements you currently take:_____

_____

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

(Mark as T = Tension P = Pain S = Spasm I = Inflammation N = Numbness/tingling)



Comments:_____

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?_____
_____

Circle any of the following health conditions that you currently have (If you are unsure, please ask. Please answer honestly, as massage may not be indicated for these conditions.):

blood clots, infections, congestive heart failure, contagious diseases, pitted edema

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain _____
Current Past Muscle or joint stiffness _____
Current Past Numbness or tingling _____
Current Past Swelling _____
Current Past Bruise easily _____
Current Past Sensitive to touch/pressure _____
Current Past High/Low blood pressure _____
Current Past Stroke, heart attack _____
Current Past Varicose veins _____
Current Past Shortness of breath, asthma _____
Current Past Cancer _____
Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current Past Epilepsy, seizures _____
Current Past Headaches, Migraines _____
Current Past Dizziness, ringing in the ears _____
Current Past Digestive conditions (e.g. Crohn's, IBS) _____
Current Past Gas, bloating, constipation _____
Current Past Kidney disease, infection _____
Current Past Arthritis (rheumatoid, osteoarthritis) _____
Current Past Osteoporosis, degenerative spine/disk _____
Current Past Scoliosis _____
Current Past Broken bones _____
Current Past Allergies (lavender/lanolin/topicals) _____
Current Past Diabetes _____
Current Past Endocrine/thyroid conditions _____
Current Past Depression, anxiety _____
Current Past Memory Loss, confusion, easily overwhelmed _____

Comments:_____
_____