Servant Hands

WOMEN'S THERAPEUTIC MASSAGE

Renee George, LMT

Licensed Massage Therapist

CLIENT INTAKE FORM

Name:	Date:
Address:	Date of Birth:
City / State / Zip:	Home Phone:
Email:	Cell Phone:

*Your contact information will not be sold or given to any third party.

Appointment reminders will be sent via e-mail and text two days before your appointment unless otherwise noted here:

_____

Would you like to be contacted regarding massage specials? **YES** **NO**

Occupation: _____ Other Physical Activities: _____

Emergency Contact: _____ Relationship _____ Phone: _____

Physician: _____ Phone: _____

Medical & Health History

General Health Condition: **EXCELLENT** **GOOD** **FAIR** **POOR**

Specify areas you are having difficulty: _____

Are you seeing a physician, chiropractor, or physical therapist for this issue / injury? **YES** **NO**

PLEASE MARK ALL CURRENT AND PAST CONDITIONS:

- ☐ Arthritis/Joint Disorder
- ☐ Blood Clots
- ☐ Contagious Skin Condition
- ☐ Easy Bruising
- ☐ Joint Replacement
- ☐ Open Sores or Wounds
- ☐ Swollen Glands
- ☐ Varicose Veins
- ☐ Difficulty breathing
- ☐ Heart Condition
- ☐ High/Low Blood Pressure
- ☐ Pacemaker
- ☐ Recent Accident/Injury
- ☐ Recent Fracture
- ☐ Recent Surgery
- ☐ Sprains/Strains
- ☐ Atherosclerosis
- ☐ Cancer
- ☐ Circulatory Diseases
- ☐ Contagious Diseases
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Kidney problems
- ☐ Osteoporosis
- ☐ Allergies/Sensitivities
- ☐ Carpal Tunnel
- ☐ Fibromyalgia
- ☐ Frozen Shoulder
- ☐ Headaches/Migraines
- ☐ Tennis Elbow
- ☐ TMJ
- ☐ Pregnant (How many months?_____)

Please explain any checked conditions listed above and anything else you think your therapist should be aware of:

_____

_____

Please list any medications you are currently taking: _____

_____