Confidential Client Intake Form

Personal Info

Name:_____ Date:_____

Address:_____

_____

Phone:_____ Email:_____

Occupation:_____

Emergency Contact:_____ Em. Phone:_____

Medical History

Are you currently under a physician's care for any medical condition? Circle **YES** or **NO**

If yes, please explain:_____

_____

Are you currently pregnant? Circle **YES** or **NO**

Are you currently taking ANY medications including pain relievers, aspirin, blood thinners, prescriptions etc, if yes, please explain?_____

_____

Do you have any areas of concern, or unidentified, mysterious lumps, masses, rashes, patches, bruises, etc? If yes, please explain:_____

_____

Please circle ALL that apply

Acute Disorders
Allergies
Asthma
Bladder infection
Blood clots
Bruise easily
Bulging disc
Cancer
Carpal tunnel syndrome
Congestive heart failure
Contagious diseases
Diabetes
Edema
Eczema
Epilepsy
Headaches
Heart disease
Hepatitis
Sciatica
Sinus infection
Strep throat
Tendonitis
Thoracic outlet syndrome
Torticollis
Varicose veins
Virus/ Cold/ Flu

Please list any condition that may apply that's not listed above:_____

_____

_____

By signing below, I agree that the above information is truthful and I have not withheld any information that may be necessary for me to safely receive massage therapy. I also understand that massage is not intended to be mistaken for medical care and the therapist is not to diagnose or treat illnesses or diseases. I understand that the massage may be terminated for any just reasons deemed by the therapist. I also have the right to stop the massage at any time, but may be responsible for payment of full fee. I freely give my permission to receive massage therapy and release the therapist of all liability due to false statements or withholding information given by me.

Signature:_____ Date:_____