Client Intake Form

Today's Date: _____

Full Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Physician: _____ Phone: _____

How did you find out about my services?

_____

Why are you getting a massage today?

_____

Are there any specific areas of your body that need attention?

_____

Medical History

Medications being taken (Prescription, Over the Counter, Herbal, Supplements):

_____

_____

Do you use any of the following? How Often?

Caffeine: _____ Nicotine: _____ Alcohol: _____

Sugar: _____

What kinds of stress relieving activities do you participate in (Exercise, Hobbies, Sports, Etc…)?

_____

_____

_____

Please indicate any of the following conditions that apply to you. If they are a **current condition** mark with an **X** if they are a **past condition** mark with an O.

☐Recent Injuries
☐Hyperactivity
☐Abnormal Skin Condition
☐Rashes
☐Shingles/Herpes
☐Cold Hands or Feet
☐Warts
☐Rosacea
☐Boils
☐Fungal Infections
☐Heart Circulation Problems
☐Anemia
☐Bruise Easily
☐Blood Clots
☐Heart Attack
☐Aneurysm
☐Atherosclerosis
☐High Blood Pressure
☐Low Blood Pressure
☐Varicose Veins
☐GERD
☐Ulcers
☐Diverticular Disease
☐Irritable Bowel Syndrome
☐Gallstones
☐Hernia
☐Indigestion
☐Diarrhea
☐Constipation
☐Gas/Bloating
☐Indigestion
☐Loss of Appetite

☐Fatigue
☐Dizziness
☐Fibromyalgia
☐Sprains
☐Strains
☐Shin Splints
☐Spasms
☐Cramps
☐Osteoporosis
☐Scoliosis
☐Gout
☐Bunions
☐Bursitis
☐Arthritis
☐Tendinitis
☐Joint Surgery
☐Whiplash
☐Carpal Tunnel
☐Flat Feet
☐Sinus Conditions
☐Edema
☐Swollen Ankles
☐Lupus
☐Diabetes
☐Kidney Stones
☐Pregnancies
☐Hysterectomy
☐Birth Control
☐Prostate Problems
☐Reproductive Concerns
☐Menopause

☐Nervous System Condition
☐Neck/Back Injuries
☐Tremor
☐Shingles
☐Meningitis
☐Panic Attack
☐Anxiety Disorders
☐ADHD
☐ALS
☐Depression
☐Eating Disorders
☐Stroke
☐Trigeminal Neuralgia
☐Headaches
☐Learning Difficulties
☐Memory Loss
☐Trouble Concentrating
☐Trouble Sleeping
☐Allergies
☐ Asthma
☐Tuberculosis
☐Numbness
☐Hearing Problems
☐Vision Problems
☐Contacts
☐Major Accident
☐Tumors
☐Cancer

Explain any conditions noted above:

_____

_____

_____

Explain any conditions that are not listed above:

_____

_____

_____