CLIENT IN-TAKE FORM (Please print clearly)

Name _____Email _____

□***Yes! Please add me to your e-mail list so that I can be notified of specials and events.***

Phone numbers: Day _____ Evening_____

Address_____ City _____ State ___ Zip _____

Age _____ Date of birth _____ M ____ F ____ Height _____ Weight _____

Occupation _____

*Emergency contact name & number _____

Have you received professional massage before? Circle Yes / No

What brings you in for a massage today? Relaxation __ / Therapeutic treatment ___/ Sports ___

How did you hear about us? □Google □Yelp □Angie's List □SpaFinder □Print Ad □Flyer

□Referral _____ □Other _____

What is your major area of pain or concern? _____

_____

When did you first notice it? _____ What brought it on? _____

What activities aggravate it? _____

Is this condition getting worse? Yes / No Does it interfere with work __ sleep___recreation ___

What have you done to get relief? _____

Has there been a medical diagnosis? _____

By whom? _____

Are you pregnant? Circle Yes / No Due date: _____

Are you presently under a doctor's care for any other condition? Yes / No

If so, for what condition? _____

Name of physician _____ Phone _____

Are you taking any: ( ) medications List them _____

( ) Insulin ( ) Blood thinners ( ) Pain pills (type: _____)

Operations (in last 3 yrs) _____

Broken bones (in last 3 yrs) _____

Accidents or injuries that may affect the massage

_____

Do you have a history of: (please check all that apply)

□ headaches/migraines	□ shooting pains _____	□ dizziness/loss of balance
□ pins & needles _____	□ high blood pressure	□ blood clots, phlebitis _____
□ anemia/bruise easily	□ allergies _____	□ skin disorders/rashes _____
□ diabetes	□ arthritis/painful joints	□ cancer _____
□ numb hands ____or feet ____	□ varicose veins	□ pinched nerves _____
□ heart condition _____	□ spinal/disk conditions _____	

other _____

I hereby certify that I have filled out this form as accurately as possible, and I take sole responsibility to advise the therapist giving me the massage as to how it feels, favorably or adversely, and full responsibility to the results. I agree to give **24 hours notice if I need to cancel** my appointment. If I do not give 24 hours notice, I agree to pay the cancellation fee. Eye Street will take emergencies into consideration.

Client's signature _____ Date _____

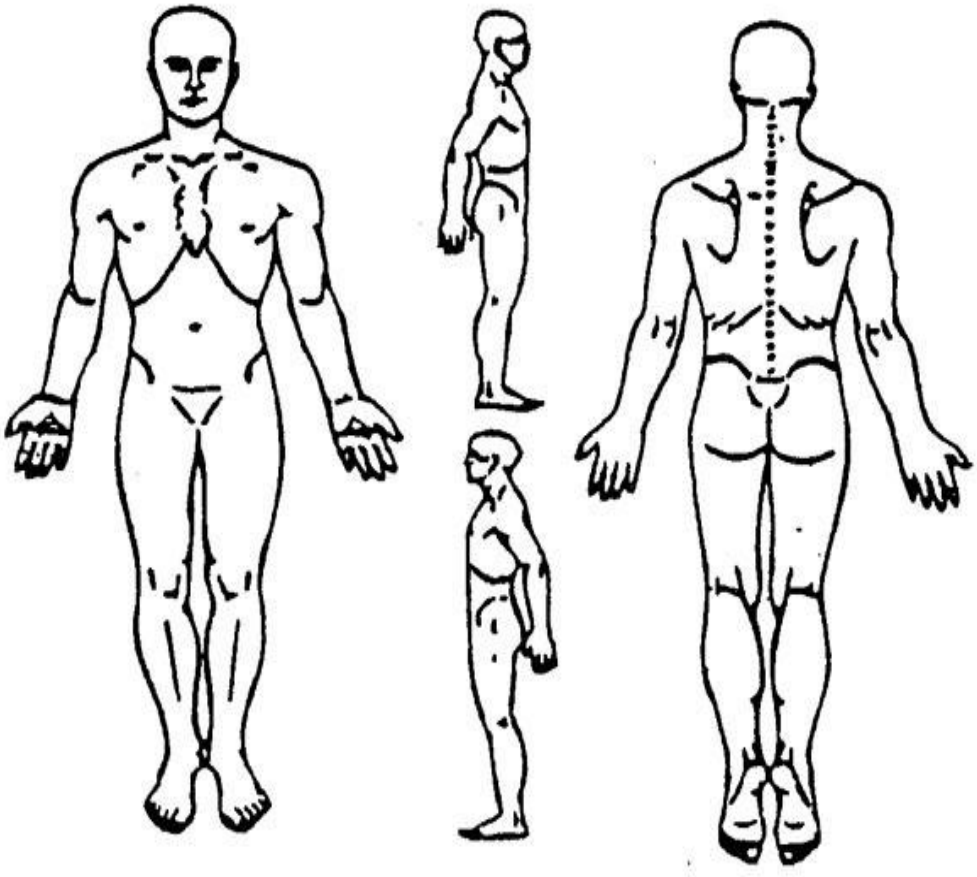
Therapist's signature _____ Date _____

PLEASE COMPLETE THE NEXT PAGE

Client Name: _____

Please indicate areas of pain or tension on the figures below.
The symbols listed will allow you to be more specific.

Pain	+++
Numbness	- - - -
Tension	////



Notes:

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