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.***
□***Yes! Please add me to your text message 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
□A-frame Sign □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 _____

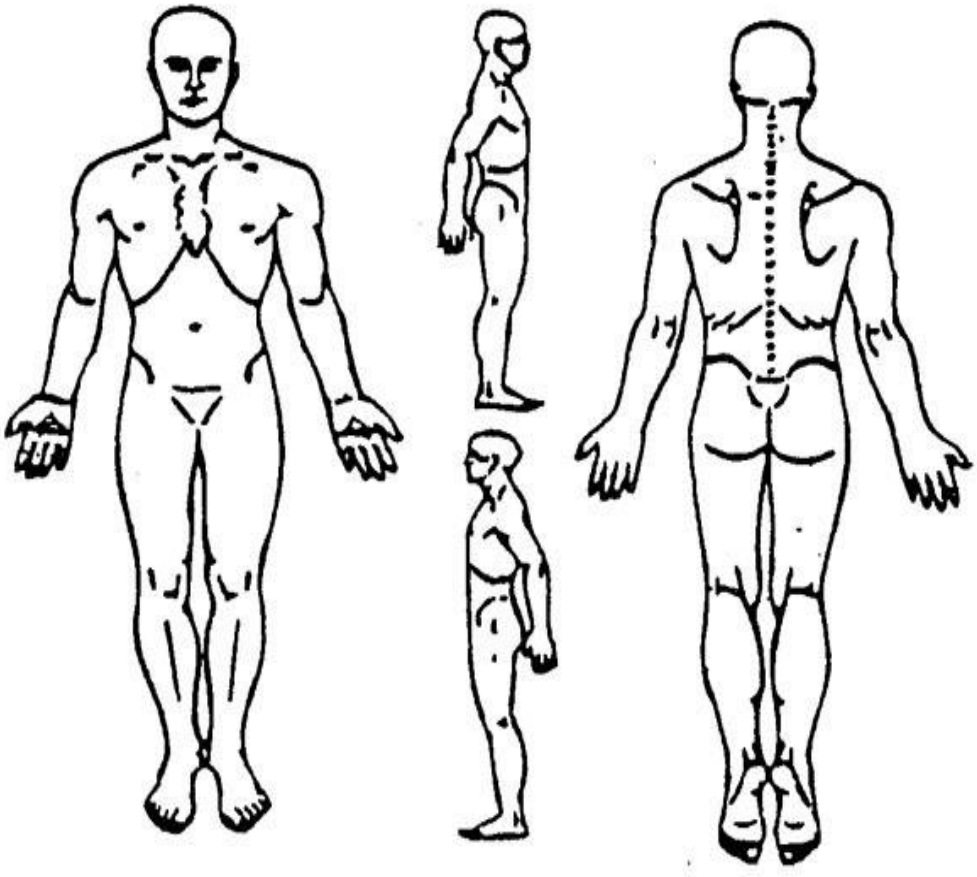
Therapist's signature _____ Date _____

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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