CLIENT IN-TAKE FORM

Please print clearly. In cases of multiple choice, please circle all that apply.

Name_____ Email _____

☐ *Yes, please add me to your **e-mail list** so that I may be notified of events & promotions.*
☐ *No, thanks, I want to receive **emails only for appointment confirmations, reminders & receipts**.*
☐ *Yes, please add me to your **text message list** so that I can be notified of events & promotions.*

Phone numbers: Day _____ Eve._____
Address_____ City/St/Zip _____
Age_____ D.O.B. _____ M / F / Non binary Height _____ Weight_____
*Emergency contact name & number _____

Are you allergic to any skin products, detergents or smells? _____
Are you pregnant? Yes / No Trimester: 1st/2nd/3rd Due date: _____ Any health concerns? Yes / No
Have you previously received massage? Yes, many times / Yes, a little / No, first massage ever
What is your primary goal for treatment right now? ___ Rest/Relax ___ Reduce Stress ___Chronic Pain ___ Acute Pain or Injury __ Other _____
Preferred massage pressure: Light / Average / Deep / I'd like to discuss my pain threshold with you
Regular activities (occupation, care-taking, hobbies, exercise, etc.): _____
_____
What is your primary form of transportation: car / bike / foot / metro. Hours per day _____
Are there other physical demands on your body? _____
Describe what you do that helps you stay healthy? (exercise, diet, self-care, wellness practices, etc.)
_____
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? (Circle)
What have you done to get relief? _____
Has there been a medical diagnosis? _____
By whom? _____
Are you presently under a doctor's care for any other condition? Yes / No
If yes, for what condition? _____
Physician's name & facility: _____ Phone_____
Please list medications you are currently taking (including non-prescription painkillers) & their purpose.
Insulin / Blood thinners / Pain pills type _____
Car accidents or other injuries that may affect the massage _____
Broken bones _____
Surgeries _____

Do you have a history of: (please check all that apply; add details as necessary)

☐Anemia/bruise easily	☐Autoimmune disorders	☐Arthritis/bursitis
☐Blood pressure high/low	☐Blood clots/DVT	☐Cancer
☐Carpal Tunnel Syndrome	☐Depression/Anxiety	☐Diabetes
☐Epilepsy or seizures	☐Heart condition	☐Immune deficiency
☐Insomnia/sleep disorder	☐Joint injury/dislocation/surgery/replacement	☐Migraines/headaches
☐Numb or tingling feet	☐Numb or tingling hands	☐Wear a pacemaker
☐Pinched nerves	☐PTSD or trauma	☐Plantar fascitis

☐Shooting pains	☐Skin disorders/rashes	☐Spinal or disk injuries or surgery _____
☐Tendonitis	☐Thoracic outlet syndrome	☐TMJD or teeth grinding/clenching
☐Varicose veins	☐Whiplash or neck injury	☐

Other medical concerns?_____
Are there aspects of your health history you'd like to share?_____

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. If I do not give **24 hours notice** for cancellation I will pay the cancellation fee.

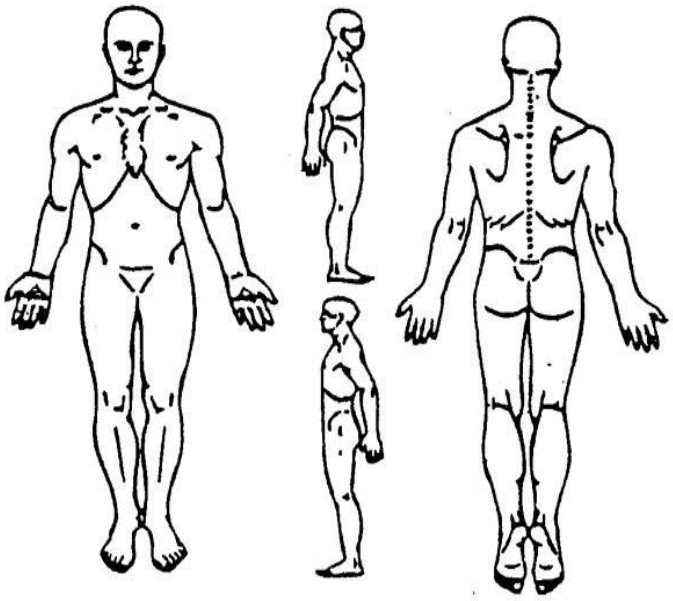
Client's signature _____ Date _____

Therapist's signature _____ Date _____

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

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

R L L R



Notes:_____