Therapeutic Massage - Confidential Client Intake Form

Personal Information

Name _____ Phone (_____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____ Occupation: _____ o Male o Female

Emergency Contact: _____ Phone (_____) _____ Physician _____

Massage Information

How did you hear about us? _____

Have you ever had professional massage before? o Yes o No How recently? _____

What kind of pressure do you prefer? o Light o Medium o Firm

What type of massage are you seeking today? o Relaxation o Deep Tissue/Therapeutic o Pregnancy

o Sports o Energy Work o Integrated Bodywork o Other _____

Are you sensitive to fragrances or perfumes? o Yes o No

If yes, what? _____

Do you have sensitive skin? o Yes o No

Do you wear contact lenses? o Yes o No

Do you exercise regularly? o Yes o No

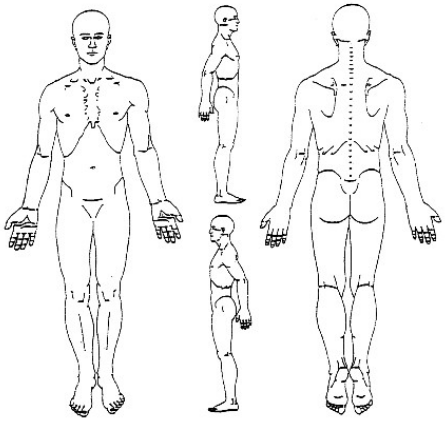
If so, what type(s)? _____

_____

What are your common areas of pain or tension?

_____

_____



Please use the body diagrams to the right to indicate any areas you would like the massage therapist to concentrate on.

Medical History

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided

Do you suffer from chronic or persistent pain/discomfort? _____ If so, for how long? _____

Do you know what caused it/what makes the symptoms better or worse? _____

Do you see a chiropractor? o Yes o No If so, how often? _____

Are you currently under medical care? o Yes o No