

Client Intake Form

Please print clearly.

Date: _____

Name: _____

First

Last

Date of Birth: ____/____/____ Marital Status: _____

Occupation: _____ Date of Last Massage: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____

Cell: _____ Email: _____

Primary Health Care Provider: _____

Permission to Consult with Primary Provider? (Y/N) _____ If yes, please initial: _____

Are you currently under other practitioners' care? Acupuncturist Chiropractor Herbalist
Nutritionist Physical Therapist Other: _____

Referred by (please circle): Sign Card Brochure Friend/Family Yellow Pages
Newspaper Magazine Flyer Website Other: _____

Purpose for massage (circle): Promote Health Relaxation Rehabilitation
Stress Relief Pain Relief

Do you suffer from frequent headaches? (Y/N) _____

Do you have allergies to lavender/lanolin/anything?: _____

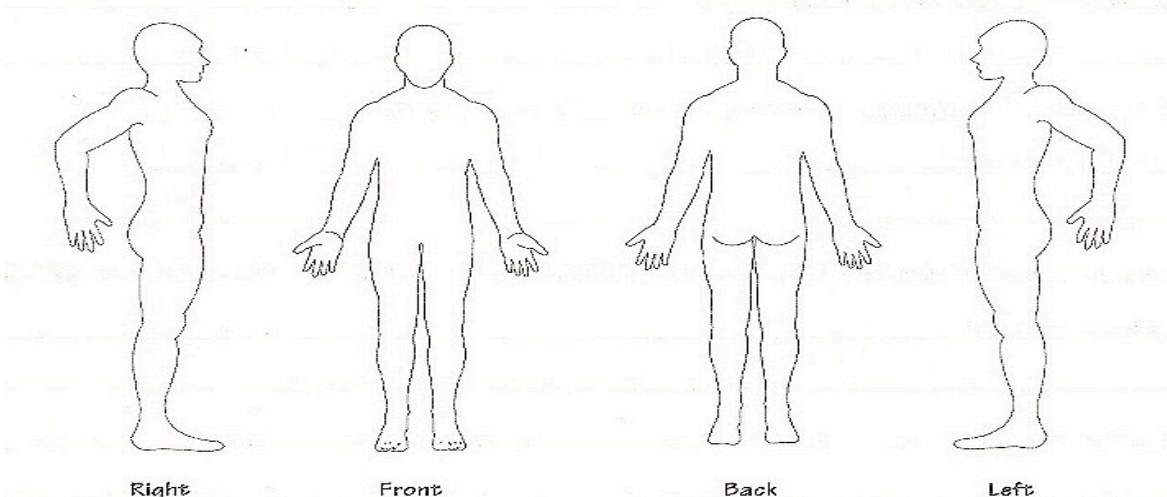
Please list all medications & supplements you are currently taking: _____

Please list any cardiovascular/circulation issues you may have: _____

Please list all other surgeries/conditions/concerns: _____

Are you pregnant? (Y/N) _____ How many weeks? _____

Please indicate areas of tension or pain in your body on the diagrams below:



Comments: _____