SHARI FISHEL, CERTIFIED MASSAGE THERAPIST
CALIFORNIA MASSAGE THERAPY COUNCIL, CERT. #55836

CLIENT INTAKE FORM

DATE: _____

NAME: _____ SEX: ❒ MALE ❒ FEMALE
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ CELL PHONE: _____
EMAIL ADDRESS: _____

WORK PHONE: _____ OCCUPATION: _____
EMPLOYER: _____

DATE OF BIRTH: _____ MARITAL STATUS: ❒ SINGLE ❒ MARRIED
NAME OF SPOUSE/SIGNIFICANT OTHER: _____
REFERRED BY: _____

HAVE YOU EVER HAD A PROFESSIONAL MASSAGE? ____YES ____ NO
IF SO, HOW RECENTLY? _____

WHAT ARE YOUR GOALS/CONCERNS FOR TODAY'S TREATMENT? _____
_____

DO YOU EXPERIENCE ANY DIFFICULTY LYING ON EITHER YOUR FRONT OR YOUR BACK? ____
_____

POSTURE ASSUMED MOST OF THE DAY _____
(I.E. SEATED AT COMPUTER, ETC.)
IS THERE A SPECIFIC AREA WHERE YOU WOULD LIKE EXTRA TIME SPENT, AN AREA THAT SEEMS TO HOLD A LOT OF TENSION? _____
_____

ARE YOU CURRENTLY UNDER MEDICAL/THERAPEUTIC TREATMENT? ❒ YES ❒ NO
IF YES, FOR WHAT CONDITION? _____
_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:
NAME: _____ TELEPHONE #: _____
ADDRESS: _____
RELATIONSHIP: _____

PLEASE LIST ANY MEDICATIONS (INCLUDING OVER-THE-COUNTER, PRESCRIPTION, AND NUTRITIONAL SUPPLEMENTS) THAT YOU ARE TAKING: _____
_____