MASSAGE CLIENT INTAKE FORM

NAME: _____ DATE: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

DOB: _____ OCCUPATION: _____

REFERRED BY: _____ PHYSICIAN: _____

HAVE YOU EVER HAD MASSAGE THERAPY? _____

LIST MEDICATIONS YOU TAKE REGULARLY _____

HAVE YOU EVER HAD ANY SURGERY? _____

IF YES, WHAT AND WHEN? _____

ARE YOU INVOLVED IN A REGULAR EXERCISE PROGRAM? _____

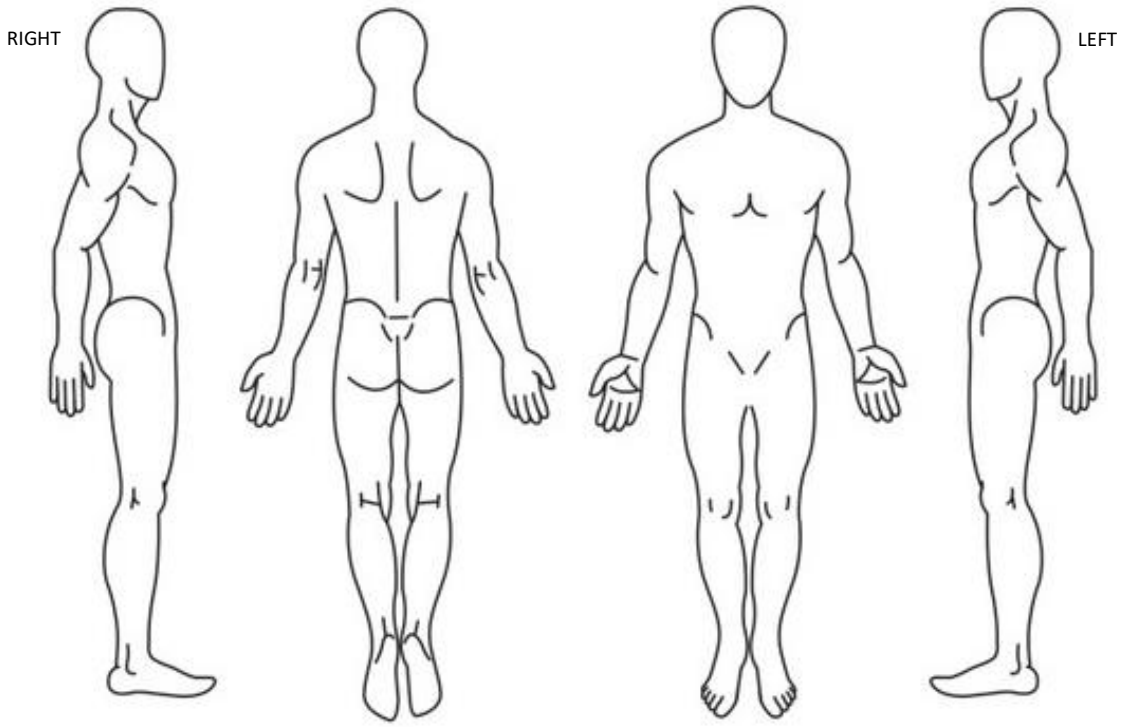
WHAT KIND OF EXERCISE? _____ HOW OFTEN? _____

DO YOU EVER SEE A CHIROPRACTOR? _____ WHO? _____

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY

ASTHMA	ARTERIOSCLEROSIS	PREGNANCY	DIABETES
ARTHRITIS	HEADACHE	VARICOSE VEINS	HERNIA
STOMACH ULCERS	EPILEPSY	DIZZINESS	CANCER
SKIN TROUBLE	PINS OR PACEMAKER	DEPRESSION	HEMOPHILIA
HIGH BLOOD PRESSURE	BRUISING TENDENCY	CONTACT LENSES	PHLEBITIS
LOW BLOD PRESSURE	HEART DISEASE		

PLEASE CHECK PROBLEM AREAS BELOW



PLEASE NOTE THERE IS A 24 HOUR CANCELLATION POLICY.

SIGNATURE: _____