

# NEW CLIENT INTAKE FORM

## MESSAGE THERAPY SERVICES

### PERSONAL INFORMATION

Name \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ DOB \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
How Did You Hear About Us? \_\_\_\_\_

### MEDICAL INFORMATION

Are you taking any medications?  Yes  No  
If yes, please list: \_\_\_\_\_

Are you currently pregnant?  Yes  No  
If yes, how far along? \_\_\_\_\_  
Any high risk factors? \_\_\_\_\_

Do you suffer from chronic pain?  Yes  No  
If yes, please explain \_\_\_\_\_  
What makes it better? \_\_\_\_\_  
What makes it worse? \_\_\_\_\_

Do you currently have any injuries?  Yes  No  
If yes, please explain \_\_\_\_\_

Please indicate any of these conditions that apply to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |

### MESSAGE INFORMATION

Have you had a professional massage before?  Yes  No

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

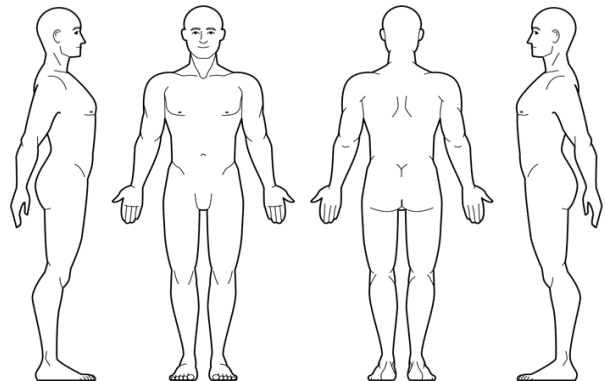
Other \_\_\_\_\_

What pressure do you prefer?  
 Light  Medium  Deep

Do you have any allergies or sensitivities?  Yes  No  
Please explain \_\_\_\_\_

Are there any areas you don't want massaged?  Yes  No

Please circle any areas of discomfort or tenderness:



Please explain any conditions or areas of discomfort you have marked above: \_\_\_\_\_

*I have completed this form to the best of my ability, and I agree to inform my therapist if any of the above information changes:*

**Print Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_