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CLIENT INTAKE
DATE_____

PATIENT INFORMATION

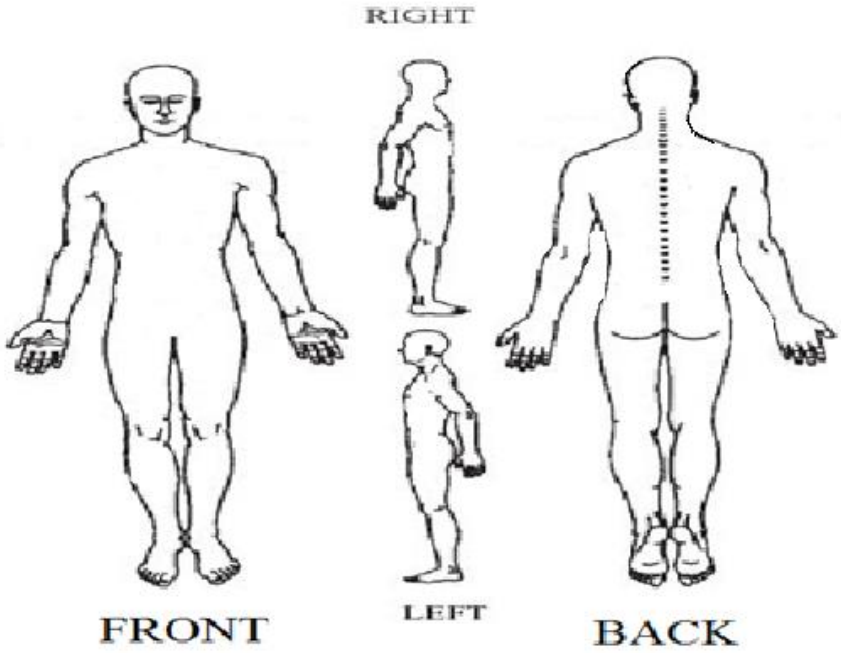
NAME		**D.O.B**
ADDRESS		
CITY, STATE, ZIP		
PHONE #'s	**CELL**	**HOME**
EMAIL		
INSURANCE CARRIER		**TYPE? [ ] CAR [ ] HEALTH**
MEMBER / CLAIM #	**Group #**	**Date of Incident**
EMERGENCY CONTACT NAME		**PHONE #**

Massage Intake & Health History

The following information will be used to help plan safe and effective massage sessions.

Please mark any problematic areas on the body map

(*) Areas of pain or soreness (XX) Areas of tightness (@) Areas of numbness/tingling



Please answer the following questions to the best of your knowledge:

1. Have you ever received a massage before? [ ] YES [ ] NO

~ Please continue on reverse ~

2. What are your current goals for your massage today?

3. Please list any activities or sports that you participate and indicate frequency/intensity.

4. Are there any factors in your life that contribute to stress?

5. What do you do to reduce stress?

6. Please list current medications you are taking (Including Supplements & Over-the-counter medications)

Do you have any current or previous conditions listed below (please check all that apply).

[ ] Abdominal / digestive problems
[ ] Allergies/sensitivity
[ ] Arthritis/Tendonitis
[ ] Artificial joint
[ ] Asthma or Lung problems
[ ] Blood clot problems
[ ] Broken bones or surgeries
[ ] Cancer or Tumors
[ ] Diabetes
[ ] Easy bruising
[ ] Epilepsy
[ ] Head Injuries
[ ] Heart or circulatory problems
[ ] High or Low blood pressure
[ ] Infectious Diseases Open sores or wounds
[ ] Sinus Problems
[ ] Skin Rashes, Athletes Foot
[ ] Sleep difficulties
[ ] Migraines or Constant Headaches
[ ] Any other medical condition NOT listed
[ ] _____
[ ] _____
[ ] _____

Please explain any conditions you have listed above and whether you are seeing a doctor:

WAIVER

I have stated, to the best of my ability, all medical conditions that I am aware of and will inform the Massage Practitioner of any changes to my health. I agree to immediately inform the therapist if I experience any pain or discomfort during the massage treatment, so that the pressure and strokes may meet my level of comfort. I assume all risks and responsibilities from any injury or liability that may occur as a result of this session and any future sessions with this practitioner.

Patient Signature	Date
Guardian (if under 18)	Date
Therapist Signature	Date