

# Client Intake Form

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Have you had massage before?: \_\_\_\_\_

If "yes" what was your experience like? \_\_\_\_\_

## Medical History

Health Conditions: \_\_\_\_\_

Medications/Supplements Being Taken: \_\_\_\_\_

Please indicate any of the following conditions that you currently have:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> headaches                  | <input type="checkbox"/> allergies        | <input type="checkbox"/> arthritis/tenonitis       |
| <input type="checkbox"/> cancer                     | <input type="checkbox"/> TMJ              | <input type="checkbox"/> abnormal skin condition   |
| <input type="checkbox"/> heart/circulation problems | <input type="checkbox"/> joint surgery    | <input type="checkbox"/> high / low blood pressure |
| <input type="checkbox"/> major accident(s)          | <input type="checkbox"/> varicose veins   | <input type="checkbox"/> blood clots               |
| <input type="checkbox"/> neck / back injuries       | <input type="checkbox"/> diabetes         | <input type="checkbox"/> fibromyalgia              |
| <input type="checkbox"/> numbness                   | <input type="checkbox"/> sprains, strains | <input type="checkbox"/> recent injuries           |

Explain Any Conditions You Have Marked Above:

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Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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