CLIENT INTAKE FORM

Date: ______________

Full Name: ____ **Preferred Phone:** ____

Address: ____ **City:** ________________ **State:** _______ **Zip:** ___________

DOB: _______/______/_________ **Gender Identity:** _________________ **Preferred Pronouns:** _______________________

Height: _____'_____" **Approx. Weight:** _________lbs **Occupation:** ____

Email: ____

Emergency Contact Name:	**Relationship:**	**Phone:**

What types of healthcare are you receiving? ***(Physician, Chiropractor, Acupuncture, Homeopath, etc.)***

____

Do you currently have, or recently had, any of the following conditions?:

____ Diabetes	____ Numbness or Tingling	____ High Blood Pressure
____ Arthritis	____ Headaches/Migraines	____ Heart Conditions
____ Cancer (History)	____ Skin Conditions	____ Varicose Veins
____ Allergies	____ Autoimmune Disease	____ Spinal Conditions

Please elaborate if you selected any of the above conditions:

____

Please note any recent injuries, surgeries, major accidents, or serious illness/conditions:

____

Please list any medications or supplements you are currently taking for <u>any of the above conditions</u>:

____

Are you pregnant or trying to become pregnant? _____ No _____ Yes: Due Date ____________________________

Previous massage/bodywork experience: ____ Never ____ Occasionally ____ Often: Type(s) _______________________

I understand that: Massage therapy (Which include styles of: Swedish, Sports, Deep Tissue or Deep Massage) involves neither diagnosis nor treatment of any condition and is not a substitute for medical care. Draping will be used at all times. This is a full-body massage unless otherwise requested. <u>Neither breasts nor genitalia will be massaged.</u> I may itemize here any areas on my body that <u>I wish to be avoided</u>, and these will be totally avoided (itemize here if relevant):

<u>If I am uncomfortable for any reason I may request to end the session and it will end promptly</u>. If client is under the age of 17, written consent from client's guardian or parent is required. I affirm that I am able to receive Massage Therapy and that any of the information I have provided above does not prohibit me from doing so. I am aware that if I have a medical diagnosis that prohibits me from receiving Massage I must provide physicians written consent prior to services.

Client Signature: ____________________________ **Therapist Signature:** ____________________________

The provided information is confidential and may be important to your therapy. Clients are asked to keep the clinic informed on changes. This is a student internship and table-side instruction may take place. Therefore, you may notice light talking between instructors and students during your treatment.