

Massage

Confidential Client Intake Form

Name _____ Date _____
Street _____ Date of Birth _____
City _____ State _____ Zip _____ Phone Hm: _____
Wk: _____
Cell: _____

Massage History/Treatment Information

List any forms of exercise or work activities. Include frequency: _____

List current medications including aspirin, ibuprofen, herbal remedies, etc. _____

Previous History (Include year and treatment received)

Surgeries: _____

Injuries/accidents (and approximate dates) _____

Major illnesses _____

Please check all that apply today:

<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Allergies
<input type="checkbox"/> Infection	<input type="checkbox"/> Heart conditions
<input type="checkbox"/> Inflammation/swelling	<input type="checkbox"/> Migraines
<input type="checkbox"/> Communicable illness (please specify):	
<input type="checkbox"/> Cancer	

Indicate areas of pain, limited range of movement, or other concern

Broad symptoms of nutritional deficiencies:

	Now	how long	Only in the past	Comments
Easily irritated	_____	_____	_____	_____
Energy problems	_____	_____	_____	_____
Acid reflux	_____	_____	_____	_____
Burping one hour After meal	_____	_____	_____	_____
Bloated 2 hours After meal	_____	_____	_____	_____
Achy articulations	_____	_____	_____	_____
Achy in the morning	_____	_____	_____	_____
Get sick easy	_____	_____	_____	_____
Memory /focus Problems	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Sleeping Disorders	_____	_____	_____	_____
Regularly Constipated or Very loose bowel	_____	_____	_____	_____
Immune modulated Disease such as Lupus, cancer, chronic Fatigue	_____	_____	_____	_____
Dry skin or Rashes	_____	_____	_____	_____