

Confidential Client History Form/ Intake Form

Date ___/___/___

Last Name _____ First Name _____ MI _____

Birthday ___/___/___ Circle: M F Address _____

City _____ State _____ Zip _____ E - mail _____

Phone (H) _____ Work _____ Cell _____

Status ___Single ___ Committed___ Employed ___ Full-Time Student ___ Part-Time Student

Referred By _____ Physician _____ Physician Phone _____

Emergency Contact _____ Phone Number _____

_____ Sometimes doing work on the body can bring out memories long forgotten or cause emotions to surface
(initial) unexpectedly. If this occurs, let me know. We'll stop and decide how to proceed.

_____ The client is responsible for payment of each massage therapy session at the time it is performed. Whatever portion of the
(initial) session(s) not covered by a third party payer is the responsibility of the client.

Primary reason for getting massage: ___Pain Relief, ___Sports performance or recovery, ___Relaxation, ___Repetative
Motion Injury

Location of Pain: _____ For how long? _____

Description of pain, circle all that apply: throbbing, pins & needles, numbness, sharp, aching, dull, burning, constant,
intermittent, occasional, other; _____

What makes the condition better/worse? _____

Have you seen a physician for this condition? If yes what diagnosis? _____

Please circle what applies to you:

HIV positive, contagious or infectious condition, cancer, any condition being medically supervised, varicose veins,
prone to bruising, contacts, dizziness, stroke, heart attack, cardio-vascular conditions, high or low blood pressure,
circulatory problems, diabetes, allergies to oils or fragrances, pregnancy

Surgeries in last 5 years _____

List all medications _____

By signing below, I verify that I am in good physical condition and the information documented is accurate and complete.
I have no physical restrictions, condition or disability which would prevent me from receiving bodywork therapy.
I hereby give my consent to have the bodywork therapy performed on me.

Client Signature _____ Date: ___/___/___

Please mark on the below chart: # surgeries, scars, bruises, or wounds; and X anywhere that is in pain and/or hurts; and 0 areas that are tight or needs extra work.

