Client Intake
Massage Form

Client information

Name______________________ Date of Birth____________________

Address____

Phone__________________________ Cell________________________

E-mail_____________________________

Sex   M   F

Have you ever received a massage before? ___________________________

Occupation_________________________ Referred by________________

Are you pregnant? Y N   Stress Level: High Med Low

Work Activity __sitting __ standing__light labor __heavy labor

What are your areas of concern? ______________________________________

Health History

Please mark a yes or no if you have or have had any of the following:

AIDS/HIV	Y	N
Allergies	Y	N
Arthritis	Y	N
Asthma	Y	N
Bleeding Disorders	Y	N
Bronchitis	Y	N
Cancer	Y	N
Chemical Dependency	Y	N
Chicken Pox	Y	N
Diabetes	Y	N
Emphysema	Y	N
Epilepsy	Y	N
Fractures	Y	N
Bruises	Y	N
Heart Disease	Y	N
Hepatitis	Y	N
Herniated Disk	Y	N

Herpes	Y	N
Measles	Y	N
Migraine Headaches	Y	N
Multiple Sclerosis	Y	N
Mumps	Y	N
Osteoporosis	Y	N
Pacemaker	Y	N
Pinched Nerve	Y	N
Psychiatric Care	Y	N
Stroke	Y	N
Tuberculosis	Y	N
Tumors	Y	N
Growths	Y	N
Ulcers	Y	N
Psoriasis	Y	N
Dermatitis	Y	N
Athletes Foot	Y	N

Client Signature ______________________________________ Date ____________