

Intrinsic Touch – Massage Therapy

Client Intake Form

First Name:		Last Name:			
Phone Number (s)					
Street Address					
City			State		Zip Code
Birth date or Age:			Birth Month:		
Email Address: (if you would like to be informed about specials and schedules)					
How did you hear about me e.g. Internet, friend, flyer, ad, other?					
Occupation & Work Duties (computer, sitting, lifting, telephone, etc.)					
<i>Massage Experience (how often / type)</i>					
Are there any areas you would like me to avoid (ex: face, scalp, feet)					
Injury History in the last 5 years(car accidents, broken bones, dislocations, falls, etc.)					
Recent Surgeries? If so, when?					

Do you have any of the following conditions? (please check the left box for all that apply)

<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	TMJ	<input type="checkbox"/>	Carpal Tunnel	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Seizure Disorders

Please describe any areas of stiffness or pain, as best you can.

I have completed this client intake form to the best of my knowledge. I understand the massage services are designed to be a health aid and in no way substitute a physician's care when indicated. I understand massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness. If I experience any pain or discomfort during the massage, I will immediately inform the therapist so that pressure/stroke may be adjusted to my comfort. I agree to keep the therapist updated as to any changes in my medical profile and I understand there shall be no liability on the therapist's part if I fail to do so.

Signature _____ Date _____