

INTRINSIC TOUCH – MASSAGE THERAPY

Client Intake Form

1 st Name		Last Name	
Phone Number (s)			
Street Address			
City		State	Zip Code
Birth date or Age			
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.)

Massage Experience (how often / type)

Are there any areas you especially **DISLIKE** to be massaged? (ex: face, scalp, feet, abdomen)

Injury History (car accidents, broken bones, dislocations, falls, etc.)

Recent Surgeries? If so, when?

Do you have any of the following conditions? (check all that apply)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Headaches
<input type="checkbox"/> Seizure Disorders	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Skin Condition	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Allergies	<input type="checkbox"/> Numbness
<input type="checkbox"/> TMJ - Do you grind your teeth?	<input type="checkbox"/> Are you pregnant ?			

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 _____