Client Intake Form

Name_____ Date_____

Address:_____

Date of Birth_____ Home Phone(____)_____

Cell Phone (____)_____

Email Address _____

Emergency Contact_____

Phone Number(____)_____

Have you ever had a massage before? If so, when was your last? _____

_____

What kind of pressure (light, medium, firm, deep) do you prefer? _____

Are you taking medication presently?_____Yes _____No

Please list the names of all medication you are taking, and what it is for

_____

_____

Have you had a major surgical procedure or injury?_____Yes _____No

Please list the date and type of surgery

_____

_____

Are you currently seeing a chiropractor, physical therapist, or physician for an ongoing issue?

_____Yes _____No

Please describe what you are currently being treated for

_____

_____