

CLIENT INTAKE INFORMATION FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (eve) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Physician: \_\_\_\_\_

Previous experience with massage:  
\_\_\_\_\_

Primary reason for appointment / areas of pain or tension:  
\_\_\_\_\_

Emergency contact—name and number: \_\_\_\_\_

Please mark (X) for all conditions that apply now. Put a (P) for past conditions, an (F) for family history of illness.

Pain Scale: minor-1		2	3	4	5	6	7	8	9	severe-10
<input type="checkbox"/>	headaches, migraines			<input type="checkbox"/>	chronic pain				<input type="checkbox"/>	fatigue
<input type="checkbox"/>	vision problems, contact lenses			<input type="checkbox"/>	muscle or joint pain				<input type="checkbox"/>	tension, stress
<input type="checkbox"/>	hearing problems, deafness			<input type="checkbox"/>	muscle, bone injuries				<input type="checkbox"/>	depression
<input type="checkbox"/>	injuries to face or head			<input type="checkbox"/>	numbness or tingling				<input type="checkbox"/>	sleep difficulties
<input type="checkbox"/>	sinus problems			<input type="checkbox"/>	sprains, strains				<input type="checkbox"/>	allergies, sensitivities
<input type="checkbox"/>	dental bridges, braces			<input type="checkbox"/>	arthritis, tendinitis				<input type="checkbox"/>	rashes, athlete's foot
<input type="checkbox"/>	jaw pain, TMJ problems			<input type="checkbox"/>	cancer, tumors				<input type="checkbox"/>	infectious diseases
<input type="checkbox"/>	asthma or lung conditions			<input type="checkbox"/>	spinal column disorders				<input type="checkbox"/>	blood clots
<input type="checkbox"/>	constipation, diarrhea			<input type="checkbox"/>	diabetes				<input type="checkbox"/>	varicose veins
<input type="checkbox"/>	hernia			<input type="checkbox"/>	pregnancy				<input type="checkbox"/>	high/low blood pressure
<input type="checkbox"/>	birth control, IUD			<input type="checkbox"/>	heart, circulatory problems					
<input type="checkbox"/>	abdominal or digestive problems			<input type="checkbox"/>	other medical conditions not listed					

Explain any areas noted above:  
\_\_\_\_\_  
\_\_\_\_\_

Current medications, including aspirin, ibuprofen, herbs, supplements, etc.:  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries: \_\_\_\_\_

Accidents: \_\_\_\_\_

Please list all forms and frequency of stress reduction activities, hobbies, exercise, or sports participation:  
\_\_\_\_\_  
\_\_\_\_\_