

CLIENT INTAKE FORM

Please Print

Referred by: Email Address No Have you had massage therapy/bodywork in the past?Yes No How long ago? What is the reason for your visit today? Are you under the care of a physician or other health care practitioner? Are there any areas you want to avoid having treated? Have you had any surgeries? Yes No If yes, please explain: List any medication you are now taking and what they are used for: Do you have a history of any of the following? (Check all that apply) Serious injuries Bursitis Back pain Headaches Allergies Allergy to nut oils Arthritis Skin infection Contact lenses Pregnant Recent surgery Blood clots Use of alcohol Use of tobacco Low blood pressure High blood pressure Diabetes Varicose veins Heart attack Stroke	Name				
Cell	Address		City		
Would you like to receive text message reminders for your future appointments? Y / N Date of Birth Occupation	State Zip	Phone: Home	Worl	K	
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