Client Intake Form

Date: ______________________

Name: ____ Sex: o Male o Female

Address: ____

City: ____ State: __________ Zip: ______________

Daytime Phone #: ______________________________ Evening Phone #: _____________________

Date of Birth: _________________________________ Occupation: ________________________

In Case of Emergency, Please Notify:

Name: ____ Telephone #: __________________

Relationship: ____

Primary Health Care Provider: ____

Telephone #: ____

Permission to Consult with Primary Provider? o No o Yes ____________________(please initial if yes)

Have you had any serious illness or injury? __________ If yes, please describe:

____

Have you had any major surgery/operations? __________ If so, for what:

____

Please list any medications and/or supplements you are currently taking and for what:

____

____

____

Do you wear contacts? __________

Do you have any body piercings? ____

Are you currently being treated by a Doctor, Chiropractor or other practitioner? _________
If so, for what: ____

Have you received a massage before? __________

I understand that massage services are offered as to be a health aid and are in no way meant to take the place of a doctor's care when it is indicated. Information exchanged during massage sessions is educational in nature and intended to help you become more familiar with your own health status.

Date__________ Your Signature ____