

Client Intake Form *(Please, print.)*

| | | | |
|----------------|-------------------|-------------------|---------------|
| NAME | | PHONE | () |
| ADDRESS | DOB / / | OCCUPATION | |
| | E-MAIL | | |

WORKOUT ACTIVITIES

| | | | |
|---------------------------------------|--|---|--|
| Please, list any current medications: | | Are you currently seeing a health care professional? y <input type="radio"/> n <input type="radio"/> | Previously had a massage? y <input type="radio"/> n <input type="radio"/> |
|---------------------------------------|--|---|--|

Allergies to oils, lotions, ointments, fruits, or nuts? y n If 'yes,' please list which allergies.

(Check boxes, here.)

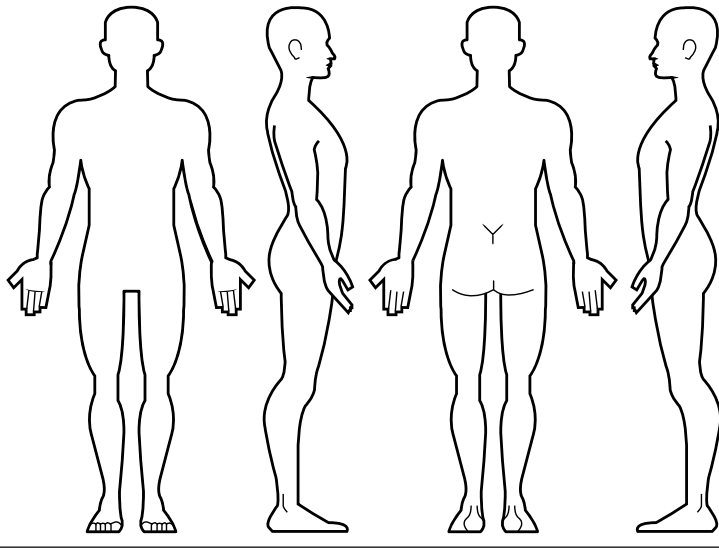
Your goal for bodywork, today? Relaxation Rehabilitation High Activity Level Maintenance

Your preferred type of touch? Light/Meditative Heavy/Invigorating Deep/Trigger Point

Please, check all that apply.

| | |
|--|---|
| <ul style="list-style-type: none"> skin conditions <input type="checkbox"/> deep vein thrombosis/ blood clots <input type="checkbox"/> bruise easily <input type="checkbox"/> recent trauma/ surgery <input type="checkbox"/> hemophilia <input type="checkbox"/> epilepsy <input type="checkbox"/> artificial joint <input type="checkbox"/> pregnancy <input type="checkbox"/> cuts/burns/ poison ivy <input type="checkbox"/> high/low blood pressure <input type="checkbox"/> allergies <input type="checkbox"/> heart condition/ pacemaker <input type="checkbox"/> phlebitis <input type="checkbox"/> | <ul style="list-style-type: none"> circulatory disorder <input type="checkbox"/> hearing aids <input type="checkbox"/> varicose veins <input type="checkbox"/> headaches/ migraines <input type="checkbox"/> insomnia <input type="checkbox"/> whiplash <input type="checkbox"/> auto immune condition <input type="checkbox"/> fibromyalgia <input type="checkbox"/> TMJ <input type="checkbox"/> carpal tunnel syndrome <input type="checkbox"/> scoliosis <input type="checkbox"/> diabetes <input type="checkbox"/> cancer <input type="checkbox"/> cold/flu <input type="checkbox"/> |
|--|---|

Please, mark areas of discomfort with an X.



FRONT RIGHT SIDE REAR LEFT SIDE

EMERGENCY CONTACT INFORMATION

| | |
|--------------|---------------|
| NAME | |
| PHONE | () |

(1.) I understand that although bodywork can be healing, relaxing and reduce muscular tension, it is not a substitute for a medical exam, diagnosis or treatment.

(2.) Sexual remarks will result in the termination of the session and I will be liable for the payment of scheduled treatment.

(3.) Understanding that bodywork should not be done under certain medical conditions, I affirm that I have answered all of the questions truthfully and to the best of my current knowledge.

CLIENT SIGNATURE

DATE