Client Intake Form

Full Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Occupation: _____

Have you had massage before?: _____

If "yes" what was your experience like?_____

Medical History

Health Conditions: _____

Medications/Supplements Being Taken: _____

Please indicate any of the following conditions that you currently have:

☐headaches	☐allergies	☐arthritis/tendonitis
☐cancer	☐TMJ	☐abnormal skin condition
☐heart/circulation problems	☐joint surgery	☐high / low blood pressure
☐major accident(s)	☐varicose veins	☐blood clots
☐neck / back injuries	☐diabetes	☐fibromyalgia
☐numbness	☐sprains, strains	☐recent injuries

Explain Any Conditions You Have Marked Above:

_____

_____

_____

Client Signature: _____ Date: _____

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