

Client Intake Form

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell Phone _____

Height: _____ Weight: _____ Birth Date: _____

Profession _____

Referred by _____

Physician's Name _____ Physician's Phone _____

Message Experience

1. Have you had a professional massage before? Yes No

2. What types of massage/bodywork have you had? _____

3. How long have you been receiving massage therapy? _____

4. Frequency of treatments? _____

5. What are your goals for treatment? _____

Current Health

6. Do you exercise regularly and/or participate in any sports? Yes No

If yes, which sports? _____

7. Have you recently suffered an injury? Yes No

If yes, describe: _____

8. Have you had any areas of inflammation? Yes No

If yes, describe: _____

9. Are you currently under the care of a physician? Yes No

If yes, explain: _____

10. Have you had recent surgery? Yes No

If yes, explain: _____

11. Medications/Allergies: _____
