Intrinsic Touch Massage Therapy - Client Intake Form

First Name:		**Last Name:**			
Primary Phone Number		**2nd:**			
Street Address					
City		**State**		**Zip Code**	
Year of Birth	**Age**	**Birth Month:**			
Email Address: (if you would like to be informed about specials)					
How did you hear about me? e.g. Internet Search, Gift Certificate, Friend					
If you heard about me from family or a friend, please put their name here:					
Occupation (please also include your work duties e.g. sitting at a computer, lifting, telephone, etc.)					
Massage Experience *(how often / type)*					
Any areas you would like me to AVOID (example: face, scalp, feet)					
Are you or have you ever been treated for cancer? If so, please describe:					
Injury History in the last 3 years(car accidents, broken bones, dislocations, falls, etc.)					
Recent Surgeries? If so, when?					

Do you have any of the following conditions? (please check the box on the RIGHT for all that apply)

Neck Pain	☐	**TMJ**	☐	**Fibromyalgia**	☐	**High Blood Pressure**	☐
Back Pain	☐	**Numbness**	☐	**Diabetes**	☐	**Low Blood Pressure**	☐
Headaches	☐	**Pregnant or Trying?**	☐	**Allergies**	☐	**Heart Condition**	☐
Vertigo	☐	**Carpal Tunnel**	☐	**Arthritis**	☐	**Scoliosis**	☐
Osteoporosis	☐	**Compromised Immune System**	☐	**Seizure Disorders**	☐	**Skin Condition**	☐
Other not listed Please describe:							

Please describe any areas where you have stiffness, pain, or areas you would like more focus

I have completed this client intake form to the best of my knowledge. I understand the massage services are designed to be a health aid and in no way substitute a physician's care when indicated. I understand massage therapists are not qualified to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness. If I experience any pain or discomfort during the massage, I will immediately inform the therapist so that pressure/stroke many be adjusted to my comfort. I agree to inform the therapist if I have any post massage concerns and agree to keep the therapist updated as to any changes in my medical profile understanding there shall be no liability on the therapist's part if I fail to do so.

Signature_____ **Date**_____