

# Intrinsic Touch – Massage Therapy

## Client Intake Form

First Name:		Last Name:			
Phone Number (s)					
Street Address					
City			State		Zip Code
Birth date or 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, Flier, Ad, other					
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.)					
<i>Massage Experience (how often / type)</i>					
Are there 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 5 years(car accidents, broken bones, dislocations, falls, etc.)					
Recent Surgeries? If so, when?					

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

<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Pregnant or Trying?	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	Carpal Tunnel	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Seizure Disorders
<input type="checkbox"/>	TMJ	<input type="checkbox"/>	Compromised Immune System	<input type="checkbox"/>	Other not listed- please describe below		

Please describe any areas of stiffness or pain, as best you can.

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 may be adjusted to my comfort. I agree to keep the therapist updated as to any changes in my medical profile and I understand there shall be no liability on the therapist's part if I fail to do so.

Signature \_\_\_\_\_ Date \_\_\_\_\_