



CLIENT INTAKE FORM

NAME _____
PHONENUMBER _____ CELL _____
EMAIL _____
ADDRESS _____ ZIP CODE _____
OCCUPATION _____ DATE OF BIRTH _____

HAVE YOU RECEIVED A PROFESSIONAL MASSAGE? YES NO

IF SO, WHAT KIND? _____

WHAT ARE YOU LOOKING TO GET OUT OF THIS SESSION? _____

LIST ANY SURGERIES AND THEIR DATES _____

HAVE YOU BROKEN OR FRACTURED ANY BONES? YES NO

SPRAINS OR STRAINS? YES NO

IF YES, PLEASE DESCRIBE AND GIVE DATES. _____

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES NO

IF YES, PLEASE LIST MEDICATION AND REASON FOR TAKING IT. _____

DO YOU EXERCISE, IF YES WHAT TYPE AND HOW OFTEN? _____

PLEASE LIST ANY OTHER ISSUES YOU FEEL ARE IMPORTANT FOR ME TO KNOW.

THE TYPE OF MASSAGE THERAPY I ANTICIPATE USING COULD INCLUDE ANY OR ALL OF THE FOLLOWING; DEEP TISSUE, SWEDISH, ACUPRESSURE, STRUCTURAL BODYWORK, THERAPEUTIC TOUCH, HOT STONE, POSTNATAL, AROMATHERAPY, SHIATSU AND OR SPORTS. THE MASSAGE THERAPY SESSION WILL FOCUS ON YOUR NECK, BACK, LEGS AND ARMS EXCLUDING ANY CONTRAINDICATED AREAS.. IF AT ANY TIME A CLIENT FEELS UNCOMFORTABLE FOR ANY REASON, THE CLIENT MAY ASK THE LICENSEE TO CEASE THE MASSAGE THEN LICENSEE WILL END THE SESSION.. ACCORDING TO TEXAS STATE DEPARTMENT OF HEALTH AND MY OWN POLICY DRAPING WILL BE USED AT ALL TIMES AND BREAST MASSAGE OF FEMALE CLIENTS WILL NOT BE PERFORMED. PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ AND UNDERSTAND EVERYTHING COVERED IN THE INITIAL CONSULTATION.

SIGNATURE OF CLIENT _____

SIGNATURE OF LICENSED MASSAGE THERAPIST _____