CLIENT INTAKE FORM

PERSONAL INFORMATION

NAME: _____

EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

AGE: _____ DOB: _____ HEIGHT: _____ WEIGHT: _____ GENDER: _____

PHONE: _____ CELL: _____ TEXT OK? Y / N

HOW DID YOU FIND US? _____ REFERRED BY: _____

OCCUPATION: _____

MEDICAL INFORMATION

Any recent INJURIES:_____

_____

Any recent SURGERIES:_____

_____

Current MEDICATIONS:_____

_____

INJECTIONS in last 30 days? Y / N If yes, What/where in the body?_____

_____

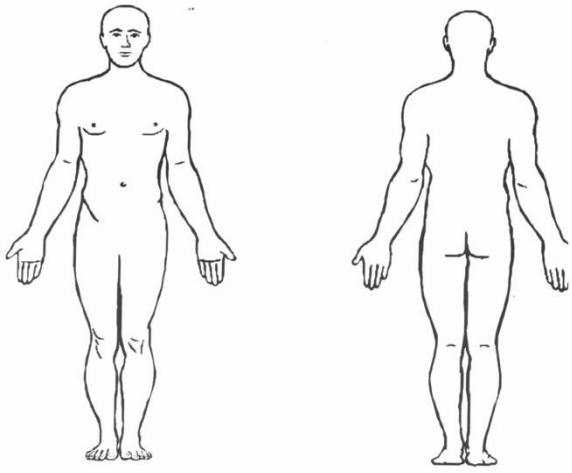
LADIES, are you pregnant? Y / N

If yes, how far along? _____

Or are you trying? Y / N

_____

MARK AREAS OF DISCOMFORT



PLEASE 'X' ANY CONDITIONS BELOW THAT APPLY TO YOU, CURRENTLY OR A HISTORY OF:

__Acute Pain	__Fluid retention	__Osteoarthritis
__Arthritis	__Fibromyalgia	__Osteoporosis
__Blood clots	__Headaches/ migraines	__Rheumatoid Arthritis
__Bulging or Herniated disc(s)	__Heart attack	__Sciatica
__Bursitis	__Low/High Blood Pressure **(*circle one*)**	__Scoliosis
__Cancer	__Joint replacement(s)	__Sinus problems
__Carpal Tunnel Syndrome	__Mechanical implants	__Skin disorders
__Chronic pain	(*pacemaker, insulin pump, etc.*)	__Stroke
__Circulatory conditions	__Metal in the body	__Sprain (*bone, joint, ligaments*)
__Cold/ Flu	(*pins, plates, screws, etc*.)	__ Strain (*muscle, tendon*)
__Deep Vein Thrombosis	Yes? What & where:_____	__Spider veins
__Diabetes	__Neuropathy	__TMJD
__Epilepsy	__Numbness	__Varicose veins

ANY OTHER MEDICAL CONDITIONS TO BE AWARE OF? _____

MASSAGE INFORMATION

Ever received professional massage therapy? __yes __no How recently _____ Frequency _____
Have you ever received cupping therapy? Y / N
If yes, from: __ Licensed Massage Therapist __ Acupuncturist __ other
What kind of pressure do you like? (Light, medium, firm, deep, in between) _____
Areas to FOCUS on during massage? _____
Areas to AVOID (areas you may *not* like to be worked like face, feet, etc.)?_____
Any allergies to oils, nuts, or lotions? __yes __no If so, what kind? _____
Goals for treatment? _____

LIFESTYLE

EXERCISE/Activity: _____ Frequency: _____
HOBBIES: _____
HOW MUCH/ day: Water _____ Caffeine_____ Alcohol _____ Smoke _____
ELIMINATION / day: Fluids _____ Solids _____
SLEEP: _____ hrs./ night Any wake-up times? _____

PLEASE INITIAL EACH ITEM BELOW:

__ I have listed all my known medical conditions and physical limitations

__ I will inform my massage therapist of any changes in my physical health.

__ I understand that the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and/or improving circulation.

__ I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

__ I am responsible for consulting my physician for any physical element that I have.

__ I am aware that I am financially responsible for my treatments at the time of appointment, unless prior arrangements have been made.

__ If at any time during the appointment I would like pressure, music, room temperature or anything else adjusted, I will inform the therapist.

__ I understand that cupping marks may result from any cupping treatment due to the release of any old stagnation and/or toxicity within the tissue.

__ I also understand that if I fail to give 24 hours' notice of canceling an appointment, that I will be responsible for designated cancellation fee, unless in the event of emergency.

CLIENT SIGNATURE: _____ DATE: _____