

Initial Session Client Intake Form

Name _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ Cell: _____

Email: _____

Occupation: _____ Referred By: _____

Have you had a massage before? Yes No How long ago? _____

If so, what pressure do you prefer? Light Medium Firm

Rate your general health: Excellent Good Fair Poor

Please describe your primary area(s) of discomfort or concern:

Emergency Contact: _____

Phone: _____ Relationship: _____

Are you under a physicians care? If so please describe: _____

Medications currently taking: _____

Do you take blood thinners? _____

Have you ever been hospitalized? Describe: _____

Please Read and Sign Below

I understand that the Massage/Reflexology work that I receive is provided for the basic purpose of relaxation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that the work should not be construed as a substitute for medical examination diagnosis, or treatment and that I should see a physician, chiropractor, or other medical specialist for any mental or physical ailment. I understand that the practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing stated in the course of the session(s) given should be construed as such.

Due to some body work being contraindicated for some conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly. I understand that there will be no liability on the practitioners part should I fail to do so.

Signed: _____ Date: _____ 

Please fill out both sides! Thank you!

Client Intake		<i>Circle All That Apply</i>		General Health Information	
General Health	Joint/Muscular	Nervous System	Eyes/Ears/Nose/Throat		
Abdominal Pain	<i>Arthritis</i>	<i>Alzheimers</i>	Cataracts		
<i>Allergies</i>	Backache	<i>Depression</i>	Colds		
Dehydration	Bursitis	Epilepsy	Conjunctivitis		
<i>Diabetes</i>	Carpal Tunnel Syn.	<i>Insomnia</i>	Vertigo		
<i>Dizziness</i>	Degen. Joints	MS	Deafness		
<i>Epilepsy</i>	Dislocation	Neuralgia	Earaches		
<i>Fatigue</i>	Fibromyalgia	Parkinsons	Eye Pain		
<i>Goiter</i>	Tendonitis	Sciatica	Failing Vision		
<i>Headaches</i>	Ganglion Cysts	Spinal Cord Injury	Gum Trouble/Disease		
<i>Migraine</i>	Gout	<i>Mental Sluggishness</i>	<i>Hay Fever</i>		
Cancer	Hernias	Tremors	Tinnitus		
<i>Hypoglycemia</i>	<i>Muscular Dyst.</i>	Anxiety	Laryngitis		
Flu	<i>Muscular Spasms</i>	Neuropathy	Nose Bleeds		
Pneumonia	Osteoporosis		Sore Throat		
<i>Wt Gain/Loss</i>	TMJ		<i>Thyroid-Hyper/Hypo</i>		
	Sprains/Strains				

Lymphatic/Circul.	Respiratory	Digestive	Genito/Urinary	Skin
Anemia	Asthma	Anorexia	<i>Miscarriage</i>	Acne
Angina/Chest Pain	<i>Bronchitis</i>	Appendicitis	Bedwetting	Allergy
Aortic Aneurysm	Cough	Bulimia	<i>Cystitis</i>	Dermatitis
Arrhythmia	Mastoiditis	<i>Candida</i>	<i>Cramps</i>	Esczema
Arteriosclerosis	Pleurisy	Colitis	<i>Endometriosis</i>	Cancer
Bleeding	Pneumonia	<i>Constipation</i>	<i>Fibroids</i>	Warts
Blood Clots	<i>Sinusitis</i>	Crohns	Hysterectomy	Dry
<i>Chronic Fatigue Syn</i>	Tonsilitis	Cystic Fybrois	Prostate Trouble	Oily
Edema	TB	Diverticulitis	Pregnancy #	
<i>Grave's</i>	Laryngitis	Gallstones	Urination Problem	
Hodgkins's	<i>Hepatitis</i>	Nausea	Kidney Stones	
Hypertension	Irritable Bowel	<i>Pancreatitis</i>	Mastectomy	
Hypotension	<i>Liver Condition</i>	Poor Appetite		
Leukemia		Ulcers		
Raynauds		Reflux		
Varicose Veins	Other Conditions Not Listed: _____			

Have you had pain or swelling in legs?: _____

Do you have numbness or tingling in feet or ankles? _____

Any current or past injuries to feet? Yes No _____

Are you sensitive to touch on the feet? _____

