WELLNESS SOLUTIONS

MASSAGE THERAPY CLIENT INTAKE FORM

All information is kept strictly confidential as required by Federal Law

Full Name: _____ Date:_____

Occupation: _____ Birthdate: _____

Phone:_____ Email (optional): _____

Address: _____

How did you hear about us? _____

Have you had a professional massage session before? ☐ Yes ☐ No

Are you currently being treated by a doctor for an illness? ☐ Yes ☐ No
If YES, please list reasons and treatments: _____

_____

List all medications and supplements you are currently taking: _____

_____

Are you experiencing any of the following today? Please check all that apply:

☐ Fever ☐ Cold/flu ☐ Open cuts/ skin rash/ new tattoo
☐ Severe pain ☐ Recent surgery ☐ Alcohol intake in the past 24 hrs
☐ Broken bones ☐ Sprained muscles ☐ Strong emotional distress
☐ Headache ☐ Anything contagious: _____

Are you experiencing physical pain today? If YES, please explain: _____

_____

Massage may be contraindicated or needs to be modified in certain conditions. Have you been diagnosed with any of the following? Please check all that apply:

☐ Arthritis ☐ Blood clots ☐ Cancer ☐ Diabetes ☐ Disk herniation
☐ Heart disease ☐ Immune dysfunction ☐ Seizures ☐ Stroke ☐ Varicose veins

Please list all your surgeries: _____

Do you experience allergic reactions to any of the following? (Please check all that apply)

☐ Environmental ☐ Nut products ☐ AC/forced air heat
☐ Essential oils ☐ Cosmetics ☐ Other: _____

Are you pregnant? ☐ Yes ☐ No If YES, how many weeks: _____

Please read and sign the Informed Consent Form. Thank you.