

MASSAGE THERAPY CLIENT INTAKE FORM



PERSONAL INFORMATION

Name: _____ DOB: ___/___/___ Sex: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone (H): _____ Phone (C): _____ E-mail: _____

Occupation: _____ How did you hear about us? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

HEALTH HISTORY

Have you received a massage before? No Yes (how often?): _____

Do you engage in physical activity? No Yes (please describe): _____

Any medical conditions/surgeries? No Yes (please describe): _____

Are you currently taking medication? No Yes (please list): _____

Do you have any contagious diseases? No Yes (please describe): _____

Do you have any severe allergies? No Yes (please describe): _____

Are you pregnant? No Yes (due date): ___/___/___

Any injuries in the past 72 hours? No Yes (please describe): _____

Do you bruise easily? No Yes

Primary reason(s) for visit today:

If applicable, how/when did this issue develop?

Have you received any prior treatment for this issue?
 No Yes (please describe): _____

I affirm that I have stated all known medical conditions and answered all questions honestly. I agree to keep the massage practitioner updated with any changes in the status of my health.

Appointment Cancellation Policy: If The Art of Health, LLC does not receive notice of an appointment change or cancellation twelve hours prior to scheduled appointment, I understand I will be responsible for a \$45.00 cancellation fee.

Signature

Printed Name

Date