The Art of Health, LLC • 2055 N. 15th St. Ste. 201• Arlington, VA 22201 • ☎ 703.340.4325

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

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