

Client Intake Form

Name: _____ Today's Date: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Primary Contact Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Work Responsibilities: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Current Health

Have you received massage therapy before? _____ How Often? _____

Exercise Activities: _____ Frequency: _____

Current Medications (including over-the-counter & herbal) _____

Check any of the following that apply to your current health:

- | | | | |
|--|--|---|---|
| Allergies / Sensitivities <input type="checkbox"/> | Contagious Diseases <input type="checkbox"/> | Heart Conditions <input type="checkbox"/> | Pregnancy <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Diabetes <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Skin / Fungal Conditions <input type="checkbox"/> |
| Blood Clots <input type="checkbox"/> | Difficulty Breathing <input type="checkbox"/> | Kidney Problems <input type="checkbox"/> | TMJ <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Epilepsy / Seizures <input type="checkbox"/> | Mental Health Issues <input type="checkbox"/> | Varicose Veins <input type="checkbox"/> |
| Circulatory Conditions <input type="checkbox"/> | Headaches / Migraines <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> | Other Disorders / Issues <input type="checkbox"/> |

Comments: _____

Check body parts (besides genitals and breasts)

Where you do **NOT** want to receive massage:

- Abdomen / Stomach Arms Buttocks
Chest Face Feet Head
Hands Legs Other _____

Previous History

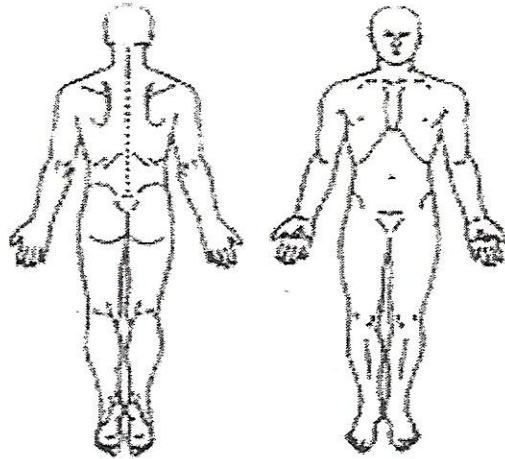
List in chronological order, stating dates or ages and treatment received:

Surgeries: _____

Accidents: _____

Major Illnesses: _____

Mark on figures all areas of pain, tenderness, numbness, stiffness, and swelling:



Consent For Care

This information is complete to the best of my knowledge. I will inform my practitioner as to any changes in the future. Should I experience discomfort during the session, I will inform my practitioner immediately. I understand there is no implied or stated guarantee of success, effectiveness, individual techniques or series of appointments – massage is in no way intended to take the place of medical care when indicated. I have no physical conditions that would be contraindicated with massage. Information exchanged during massage therapy sessions is educational in nature and to be used at my own discretion. I agree to hold **RESONATE SOURCE** therapists and practitioners harmless for any claims resulting from treatments received there.

Signature _____ Date _____