



## Client Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ how did you hear about us? \_\_\_\_\_  
 Medications currently taking: \_\_\_\_\_  
 Why are you seeking massage? \_\_\_\_\_  
 Describe any surgeries, major injuries, broken bones (use back if needed): \_\_\_\_\_

**Please check the box if you have experienced any of the following:**

<input type="checkbox"/> Sinus/Allergies <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Sciatica <input type="checkbox"/> Skin Conditions/rash where? _____ <input type="checkbox"/> Infectious Conditions Where? _____ <input type="checkbox"/> Area of Inflammation Where? _____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> Dizziness or Fainting <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Arthritis <input type="checkbox"/> Bursitis <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Diabetes  <b>Neck:</b> <input type="checkbox"/> Pain with movement <input type="checkbox"/> Stiff neck <input type="checkbox"/> Grinding and popping	<b>Hips, Legs and Feet:</b> <input type="checkbox"/> Leg or foot cramps <input type="checkbox"/> Feet feel cold <input type="checkbox"/> Swollen feet/ankles <input type="checkbox"/> Ticklish feet <input type="checkbox"/> Shooting pain <input type="checkbox"/> Hip replacement <input type="checkbox"/> Knee surgery  <b>Shoulders:</b> <input type="checkbox"/> Can't raise arm above shoulder <input type="checkbox"/> Can't raise arm overhead  <b>Head:</b> <input type="checkbox"/> TMJ <input type="checkbox"/> Grinding Teeth <input type="checkbox"/> Headaches Where? _____ <input type="checkbox"/> Memory loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sensitivity to light <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of balance <input type="checkbox"/> Head feels heavy	<b>Arms and Hands:</b> <input type="checkbox"/> Hands cold <input type="checkbox"/> Loss of grip <input type="checkbox"/> Shooting pain  <b>Low Back</b> Pain worsens when: <input type="checkbox"/> Lifting <input type="checkbox"/> Sitting <input type="checkbox"/> Laying down <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending  <b>Abdomen:</b> <input type="checkbox"/> Nausea <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Tenderness  <b>Female:</b> <input type="checkbox"/> Pregnant #of Weeks _____
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I understand that the massage I receive is provided for the basic purposes of relaxation and relief of muscular tension. If I experience any pain or discomfort during my sessions, 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 massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any ailment that I am aware of. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the sessions given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have listed all my known medical conditions and answered all questions honestly. I agree to keep my practitioners updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. If I have a specific medical condition or specific symptoms, massage may be contraindicated and a referral from my doctor may be required prior to service being provided. I understand that this clinic has a 24-hour cancellation policy and I will be liable for full payment for any appointments cancelled after this time. By signing below, I also authorize all employees and subcontractors of Pro Therapeutics, Inc. to discuss and correspond about my medical status as it pertains to providing me with safe and effective massage therapy.

Signature \_\_\_\_\_ Date: \_\_\_\_\_