For Internal Use Only
Package Type:
Package #:
Referred By:

Your Key to Wellness

Client Intake Form 2023

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ Yes ☐ No

If yes, please list name and use:_____

_____

Are you currently pregnant? ☐ Yes ☐ No

If yes, how far along?_____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ Yes ☐ No

If yes, please explain _____

_____

What makes it better? _____

_____

What makes it worse?_____

_____

Have you had any orthopedic injuries? ☐ Yes ☐ No

If yes, please list: _____

Please indicate any of the following that apply to you.

☐Cancer	☐Fibromyalgia	☐Headaches/Migraines
☐Stroke	☐Neuropathy	☐ Sprains or Strains
☐Diabetes	☐ Blood Clots	☐ Joint Replacement(s)
☐Arthritis	☐Heart Attack	☐ Kidney Dysfunction
☐Numbness	☐High/Low Blood Pressure	

Explain any conditions you have marked above:

_____

_____

_____

_____

Medical Information

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

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

☐ Prenatal ☐ Hot Stone ☐ Cupping

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ Yes ☐ No

Please explain_____

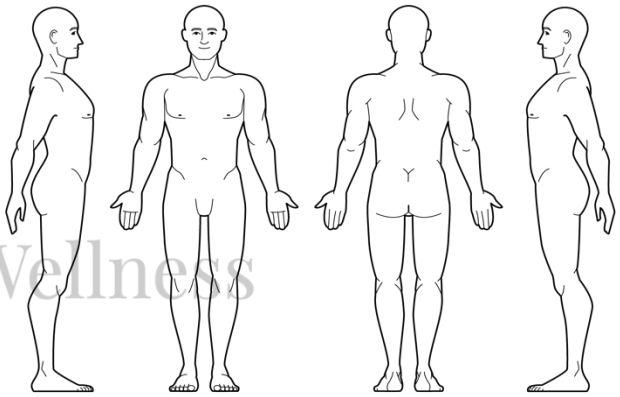
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



I have completed this form to the best of my ability and knowledge and hereby agree to inform my therapist if any of the above information changes at any time.

Client Signature_____ Date_____

Therapist Signature_____ Date_____