Confidential Intake Form

Welcome! We want to make your stay as pleasant and as comfortable as possible. If you have any questions regarding your therapy session, please let us know.

Name_____

Phone_____

Address_____

_____ zip _____

Email_____

Date of Birth_____

Occupation_____

Have you received massage therapy before?_____

Type experienced_____

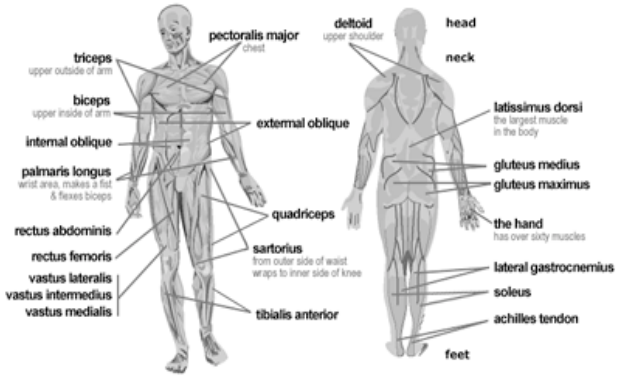
Are you taking medication? (If so, describe)

_____

Are you pregnant?_____

Allergies_____

Please circle the areas you want your therapist to focus on:



Do you have a history or are currently experiencing pain in any if the following areas?
(Circle all that apply)

- carpel tunnel syndrome
- sunburn
- open cuts/bruises
- cold/flu
- poison ivy
- inflammation
- upper back pain
- mid back pain
- lower back pain
- whiplash
- shoulder
- joint
- abdominal
- nervous tension
- headaches
- high blood pressure
- diabetes
- sciatica
- scoliosis
- arthritis, bursitis, gout
- varicose veins
- colitis
- decreased range of motion
- fibromyalgia
- breast augmentation
- sprains
- accident
- broken bones
- seizures
- stroke
- surgery
- heart attack
- cancer

Other_____

_____

Signature_____