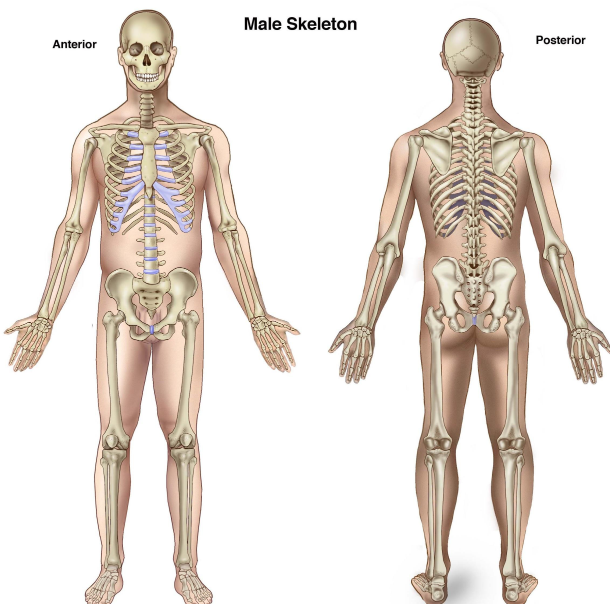
New Client Intake Form

Date:__________

Name:_____________________________________ Birthday:________________
Address: ____________________________City/Zip:________________________
Email:____________________________________ Phone:____________________
Preferred method for reminders: ___________ Occupation:_____________________
How have you heard about us: ____
Medications:____
Emergency Contact Name/Relationship:____________________Phone:__________
List Accidents or Surgeries (please include date, body region, and the outcome):____
____
____
How often do you workout or are you physically active?______________________
Have you had a massage before: Yes No Last One/Frequency:________________
Anything you did or didn't like:____
Which position do you sleep:____________Referred by:______________________
Questions or Concerns:____



How is your body feeling today?

- Draw a X where you experience pain
- Draw an arrow --> where the pain travels, if it radiates elsewhere
- Draw a N where you experience NUMBNESS or tingling
- Draw a B where you are experiencing BURNING

Signature:________________________________Date:_____________