Proactive Massage and Bodywork Client Intake Form

Name: ________________________________ Date of Birth: ______________________

Date of Wedding Anniversary: (if applicable)____

Address: ____

City, State, Zip: ____

Phone: ____________________ Email: ____

Referred by: ____

Name of Emergency Contact: ____

Emergency Contact Phone #: ____

Have you had a massage before? __________ Date of last treatment: ______________________

What would like to get out of this massage experience? Circle all that apply:

Pain Relief   Relaxation/Stress Relief   Sports Massage   Other: ________________

Your therapist will do an integrated session, however, is there a specific area (lower back, neck, feet) that you would like the massage to focus on? ____

Occupation: ____________________ How do you use your body at work? (standing, sitting, computer use, heavy objects): ____

Are you wearing contact lenses? _________ Do you exercise regularly? ____________________

Are you allergic or sensitive to any oils, lotions, candles, or scents? ___________________________

massage lotions/oils may contain fruit or nut oils, peppermint, essential oils, shea butter, ect.

Have you recently had surgery, severe illness, or an accident? If so, when did it occur?

____

Are you currently under the care of a healthcare provider for an injury or on-going illness? Please explain: ____

Are you currently taking any medications? Please list: ______________________________________

Please circle any of the following conditions that apply to you. Have you experienced?

Arthritis   Asthma   Digestive disorders   Blood clot   Edema   Foot/hand numbness   Herniated disc(s)
Phlebitis   Joint swelling   Broken bones   Skin disorders   Insomnia   Epilepsy/seizures   Carpal tunnel
Dizziness   PMS   Repressed immune system   Varicose veins   Neck pain   Back pain   Sciatica
Lo/Hi blood pressure   Osteoporosis   Cigarette smoking   Menopause   Fainting spells   TMJ   Depression
Heart condition   Headaches   Loss of balance   Fatigue   Stress   Bursitis   Cancer   Diabetes   Scoliosis
Pregnancy

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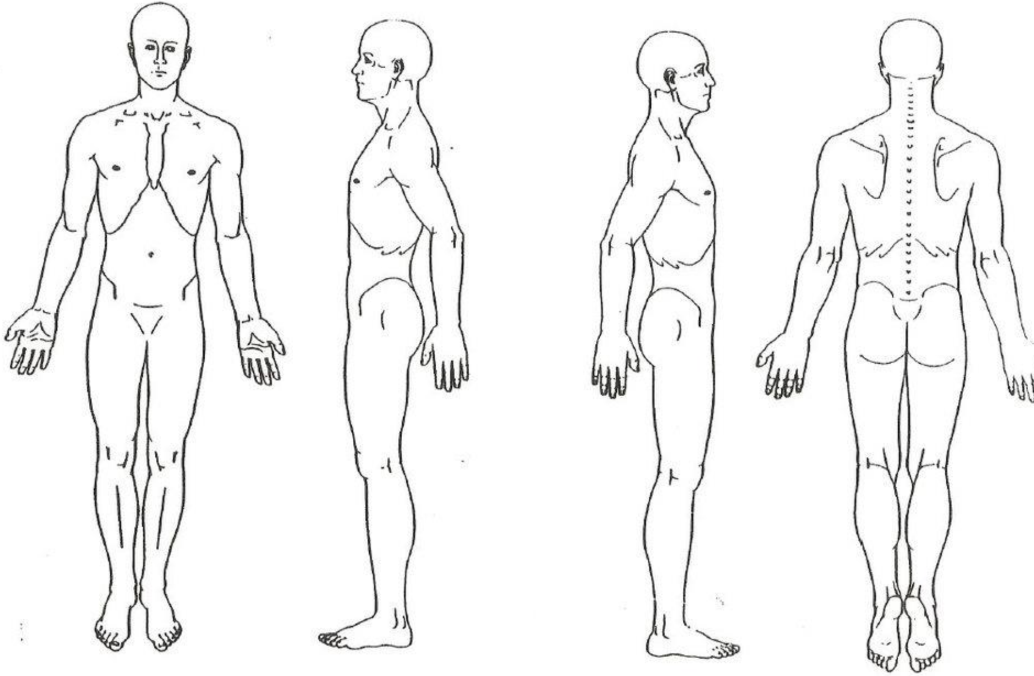
Please mark an "X" over areas of discomfort.



Any information provided by the licensed massage therapist is for educational purposes only and not diagnostic or prescriptive in nature. Your answers to the above will remain confidential and will only be used to help your therapist understand your specific needs. Please remember that payment is due when services are rendered. There will be a $25 fee for all returned checks. Please give a minimum 24-hour notice to cancel or reschedule appointments. As mandated by Virginia law, you will be draped with a sheet or towel at all times during your session. We will conduct ourselves in a professional manner at all times and expect the same of our clients. Thank you.

CLIENT SIGNATURE: _______________________________ DATE: ____________________________