

EFFECTIVE MUSCLE THERAPY

Client Intake Form

Client Name: _____ Date: _____ Date of Birth: _____

Gender: _____ Address: _____

Phone: _____ Email _____

Email: _____ Emergency contact: _____

Phone: _____ Physician/Health-care Provider Name: _____

Physician/Health-care Provider Number _____

Phone: _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.): _____

What makes your symptoms worse and what makes them better?

Please list all your medical or health issues, medications, previous injuries and surgeries

What are your goals/expected outcomes for receiving massage/bodywork? _____

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Please circle the areas(s) that are problematic:



Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner 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.

Client Signature: _____

Parent or Guardian Signature (in case of a minor): _____

Today's Date: _____