Client Intake Form

Personal Information:

Name _____ **Phone #** _____

Address _____ **City, State, Zip** _____

Email _____ **Date of Birth** _____

Gender _____ **Emergency Contact: Name** _____ **#** _____

Daily Activities:

Occupation _____ **Hobbies** _____

Sport/Athletic Activities _____ **Hours of activity/day** _____

Dominant Arm _____ **Dominant Leg** _____ **Hours of sleep/day** _____

Medical Information:

Are you currently under the care of a physician, chiropractor, physical therapist, or any other health care professional? YES NO (please circle)

Do you presently take any prescription medication, herbs, or any over the counter medication? YES NO (please circle) If YES, please list _____

_____

Are you suffering from any chronic or persistent problems such as allergies, low back pain, sciatica, arthritis, tendonitis, etc.? YES NO (please circle) If YES, please explain _____

_____

Have you, in the past 2 years, undergone any surgeries, broken any bones, or had any injuries or severe illnesses where medical treatment from a healthcare professional was needed? YES NO (please circle) If YES, please explain _____

_____

Is there any other general information or medical issues/conditions that the massage practitioner needs to be notified of? YES NO (please circle) If YES, please explain _____

_____

I, _____ (print name), agree that all of the information provided above is true and accurate to the best of my knowledge. I also acknowledge that Revive Massage Therapy is not responsible for any malpractice in regards to withholding medical information in above context.

Signature _____ **Date** _____