SWEET RELIEF
MASSAGE & RECOVER

CLIENT INTAKE FORM

Name: _____ Phone: _____ Age: _____

Address: _____

How did you hear about me? _____

Have you had massage before? _____

Have you had any broken bones, fractures or joint injuries in the last 3 years? _____

Are you presently under the care of a physician or other health professional? _____

Do you have a Pacemaker? _____

Do you have Osteoporosis or Arthritis? _____

Have you ever used any pain relieving ointments (ben gay, biofreeze). _____

What are your problem areas? _____

Please answer the following questions:

YES NO

- ☐ ☐ Are you wearing contact lenses?
- ☐ ☐ Do you have any contagious skin diseases
- ☐ ☐ Are you taking any blood thinner medication?
- ☐ ☐ Any sensitivity or allergies to lotions, creams, or any oils?
- ☐ ☐ Are you allergic to, or dislike any fragrances?

Do you have any medical conditions not yet mentioned? If so, please explain: _____

_____

If there is any information that you think I need to know to be able to give you the best possible treatment, please don't hesitate to tell me. It is you responsibility to let me know if you feel any pain or discomfort at any time All your questions are very much welcomed.

Sign: _____ Date: _____