703-801-2429

Personal Data and Health Form – Initial Client Intake Form

Name_____ Date of birth _____

Street Address_____ City _____ State_____ Zip_____

Home Phone _____ Work Phone_____ Cell Phone_____

Occupation(s)_____ Referred by:_____

Email address (Print clearly)_____

Today's primary concern/goal? _____

Have you ever had a professional massage? Yes☐ No☐ If so, how often? _____

Do you experience headaches?	Yes☐	No☐
Do you have osteoporosis?	Yes☐	No☐
Do you have trouble sleeping?	Yes☐	No☐
Do you consume excessive amounts of caffeine?	Yes☐	No☐
Do you have low back pain?	Yes☐	No☐
Do you have blood clots?	Yes☐	No☐
Do you have mental or physical stress?	Yes☐	No☐
Do you have chronic pain?	Yes☐	No☐
Do you workout regularly?	Yes☐	No☐
Have you had a recent surgery?	Yes☐	No☐
Are you pregnant?	Yes☐	No☐

Is there a particular area on your body where you tend to hold tension? If yes, explain:

_____

Is there any other medical condition we should be made aware of? If yes, explain:

_____

I have read the above information and discussed it with my practitioner. I understand that this work does not constitute medical treatment. It is a form of health and wellness maintenance utilizing the techniques of traditional Swedish massage. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. All information above will be treated confidentially.

Please note we require a 24-hour cancellation notice. Clients will be charged for missed appointments and cancellations less than 24-hours before scheduled appointment.

Signature_____ Date _____

Print name_____