getStretched & MASSAGE

Client Intake Form

Name: Date:

Referred By: Birthday:

Occupation/Employer:

Home Address: Phone – Day:

City/State: Zip: Phone – Eve:

Email Address:

Stretch Therapy History

Have you ever received a professional stretch therapy? ☐ Yes ☐ No

If yes, frequency: Last stretch session:

What results do you want from your stretch therapy sessions?

Prioritize the areas of your body that you would prefer to be stretched:

Please check the areas of your body that you give permission to be stretched:

☐ Back ☐ Legs ☐ Buttocks ☐ Arms ☐ Pecs/Chest ☐ Neck ☐

List stress reduction and exercise activities. Include frequency:

Massage Therapy History

Have you ever received a professional massage? ☐ Yes ☐ No

If yes, frequency: Last massage session:

What results do you want from your massage sessions?

Desired Pressure: ☐ Light ☐ Firm ☐ Deep

Prioritize the areas of your body that you would prefer to be massaged:

Please check the areas of your body that you give permission to be stretched:

☐ Back ☐ Legs ☐ Buttocks ☐ Arms ☐ Pecs/Chest ☐ Neck ☐

List stress reduction and exercise activities. Include frequency:

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Medical History

Please list any recent injuries, illnesses, or surgeries:

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, please explain:

List current medications (including aspirin, ibuprofen, etc):

Are there any side effects from the medication?

Do you have any chronic or frequent pain?

Are there any other medical conditions the therapist should be aware of?

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, how far along are you?

Please check all that apply

☐ AIDS/HIV+	☐ Diabetes	☐ Neck Problems
☐ Allergies	☐ Digestion Problems	☐ Now Pregnant
☐ Anemia	☐ Elimination Problems	☐ Osteoporosis
☐ Arthritis/Bursitis	☐ Fibromyalgia	☐ Sciatica
☐ Asthma	☐ Heart Problems	☐ Sinus Problems
☐ Back Problems	☐ Hi/Low Blood Pressure	☐ Stroke
☐ Bruise Easily	☐ Immovable Joints	☐ Tendonitis
☐ Cancer: Type:	☐ Kidney/Bladder	☐ TMJ
☐ Carpal Tunnel	☐ Menstrual Cramps	☐ Tumors
☐ Cold Hands/Feet	☐ Migraines/Headaches	☐ Ulcers

The information above is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the proper health care providers of my condition. I understand that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of stretch or massage therapy. If, for any reason cancellation is necessary, I will give a 24 hour notice. I understand that if I do not give this notice, I will be charged the full session rate. Emergency cancellations will be determined by therapist.

Signature: Date: