New Client Intake Form Date: _____

Name | Date of Birth | Age

Address 1

Address 2 | City | Province | Postal Code

Email address | Phone

Occupation | Referred by

Emergency Contact | Relationship | Contact Phone #

Activity frequency (ie. sports, yoga, weights, cardiovascular): _____

Previous massage frequency: _____

Reason for seeking massage: _____

Benefits or Results you would like to achieve: _____

Please check all that apply:

- o Allergies / Sensitivities
- o Arthritis / Tendonitis
- o Back / Neck Problems
- o Blood Clots
- o Cancer
- o Cramping / Spasm
- o Depression
- o Diabetes
- o Epilepsy / Seizures
- o Fatique
- o Headaches
- o Heart Condition
- o High/Low Blood Pressure
- o Infectious Condition
- o Inflammation
- o Insomnia
- o Joint Problems
- o Phlebitis
- o Pregnancy
- o Respiratory Problems
- o Sciatica
- o Sinus Problems
- o Skin Problems
- o Varicose Veins

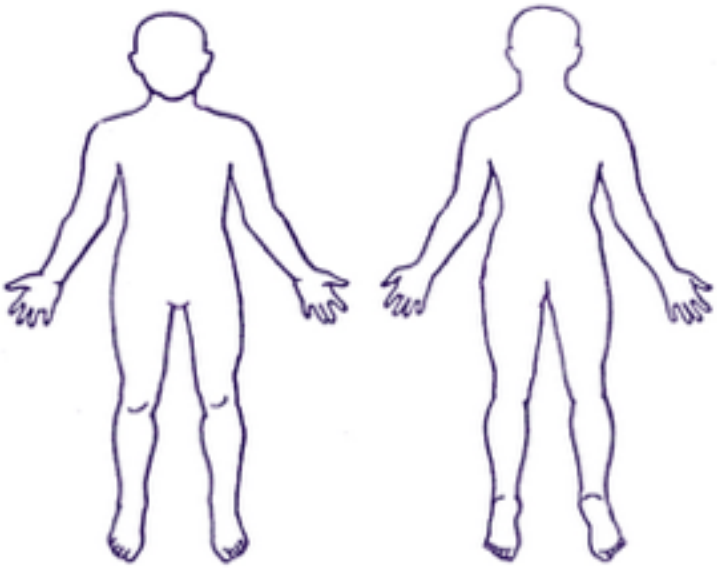
Explain any conditions that you have marked above: _____

Recent and/or Major Surgeries: _____

Medications you are currently taking: _____

Any other illness, injury or condition not listed: _____

Note any anatomical areas of tension, pain or chronic distress on the diagram



P - Sharp Pain
A - Aches
I - Inflammation
N - Numbness
S - Stiff

Indicate with an X your present levels of:

- o Health Low ---------- High
- o Energy Low ---------- High
- o Stress Low ---------- High

By signing below I hereby certify that the information provided is accurate and truthful, I acknowledge that the information provided will be kept confidential and I agree to keep my therapist updated with any changes in my health.

_____

Client Signature