



www.powermassagemn.com

Confidential Client Intake Form

Full Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (h) _____ (c) _____ Email: _____

Occupation: _____

How did you hear about Power Massage? _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Primary Care Physician: _____ Phone: _____

MEDICAL HISTORY

Medications (including vitamins/herbs): _____

Please check if you have or have had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> allergies | <input type="checkbox"/> arthritis/tendonitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> TMJ | <input type="checkbox"/> abnormal skin condition |
| <input type="checkbox"/> Heart/circulation problems | <input type="checkbox"/> joint surgery | <input type="checkbox"/> high/low blood pressure |
| <input type="checkbox"/> Major accident | <input type="checkbox"/> varicose veins | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> Neck/back injuries | <input type="checkbox"/> diabetes | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> sprains/strains | <input type="checkbox"/> recent injuries |

Explain any conditions marked above:

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination; rather, it is a form of health promotion utilizing various techniques and modalities. I take responsibility for alerting my therapist to any physical, mental or emotional changes that could affect this work.

Signature: _____ Date: _____