**At Peace Massage & Wellness - Client Intake Form** **Date: _____**

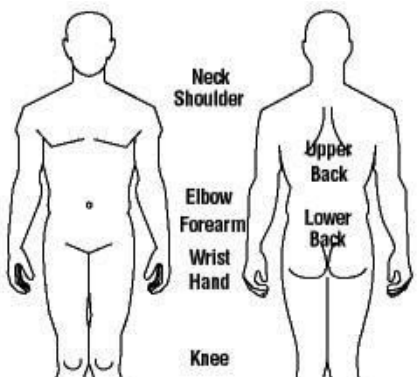
## Personal Information

Name: _____ Phone: (day/evening): _____
Address: _____ City, State, Zip:
_____
E-mail: _____Date of Birth: _____ Occupation:
_____
Emergency Contact (relation): _____ Phone:
_____
Physician Contact: _____ Phone:
_____
Chiropractor Contact : _____ Phone:
_____

## Massage Information

How did you hear about At Peace Massage?
_____
Have you ever had a professional massage before?
▢Yes ▢No
If yes, how often do you receive massage therapy? _____
What is your pressure preference?
▢Light ▢Medium ▢Deep ▢Trigger Point Therapy
What type of therapy are you seeking today?
▢Relaxation Massage ▢Therapeutic Massage
▢Prenatal Massage _____ (weeks)
Are you sensitive to fragrance or perfumes? ▢Yes ▢No
Do you have sensitive skin? ▢Yes ▢No
Do you wear contacts? ▢Yes ▢No
Do you exercise regularly? ▢Yes ▢No
Do you feel comfortable having work done on the following muscles (please initial )
Gluteus maximus _____
Abdominal _____
Pectoral_____
Do you have any difficulty lying on your front, back or side?
▢Yes ▢No
If yes, please explain to your therapist._____
Do you experience
▢muscle tension ▢ anxiety ▢ insomnia ▢irritability
Do you have any goals in mind for this massage session?
_____

**Please circle the areas you'd like to focus on.**




## Medical History

Do you suffer from chronic or persistent discomfort?
If so, for how long? _____
Do you know what caused it or when the symptoms seem to get worse or better? _____
_____
How often do you see your chiropractor?_____
Are you currently under medical care? ▢Yes▢ No
Are you currently taking any prescriptions, over the counter medications or herbal supplements? If so, please list and explain for what.
_____
_____

**Please indicate any conditions that you have had or currently have:**

▢headaches, migraines
▢allergies, sensitivity ▢arthritis,
tendonitis ▢**cancer, tumors**
▢TMJ problems
▢abnormal skin condition
▢ heart condition/circulation
problems joint replacement / surgery
▢high / low blood pressure / diabetes (pls. circle)
▢**varicose veins** (pls. indicate where)
▢ current pregnancy – Due date _____
▢**blood clots**
▢neck / back injuries
▢fibromyalgia
▢epilepsy ▢numbness,
sprains, strains recent

Injuries ▢lack of or reduced feeling / sensation

Explain conditions that you have marked above:_____

_____ **I prefer to have my therapist wear PPE during my session**

Please write anything else that you think might be important for your therapist to know:

▢ I would like to join the At Peace Massage newsletter for monthly information on how massage therapy can help!

By signing this release, I hereby waive and release my therapist from any and all liability, past, present and future relating to massage and bodywork.

_____ _____

*Signature of client* *Date*