Amy Gerard, LMT – Client Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City, State, Zip _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

Today's Date _____

Massage Information

How did you hear about me? _____

Have you ever had a professional massage before? ☐yes ☐no

If yes, how often to you receive massage therapy? _____

If yes, do you have a style or pressure preference? ☐yes ☐no

Specify : ☐ light pressure ☐ medium pressure ☐ deep pressure

☐ trigger point therapy ☐ energywork

☐ Other _____

What Type of massage are you seeking today?

☐ Relaxation ☐ Deep Tissue/Therapeutic ☐ Pregnancy

☐ Senior

☐ Other _____

If pregnant, when is your due date? _____

Are you sensitive to fragrances or perfumes? ☐yes ☐no

Do you exercise regularly? ☐ yes ☐ no

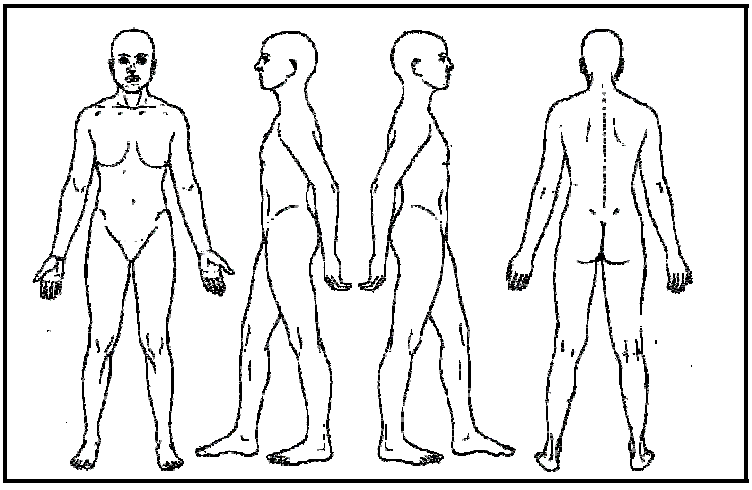
If so, what type(s)? _____

What are your common areas of pain or tension?

_____

_____

Circle any specific areas you would like me to concentrate on during the session:



Medical History

Do you suffer from chronic or persistent pain/discomfort?

_____

If so, for how long? _____

Do you know what caused it or when then symptoms seem to get worse or better? _____

_____

Do you see a chiropractor? ☐ yes ☐ no

If so, how often? _____

Are you currently under medical care? ☐ yes ☐ no

Are you currently taking any prescription medication? If so, for what? _____

_____

_____

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

☐ headaches, migraines	☐ varicose veins
☐ allergies, sensitivity	☐ pregnancy
☐ arthritis, tendonitis	☐ blood clots
☐ cancer, tumors	☐ neck / back injuries
☐ TMJ problems	☐ diabetes
☐ abnormal skin condition	☐ paralysis
☐ heart/circulation problems	☐ fibromyalgia
☐ joint replacement / surgery	☐ numbness
☐ high / low blood pressure	☐ sprains, strains
☐ major accident	☐ recent injuries

☐ lack of or reduced feeling / sensation _____

Explain any conditions that you have marked above:

_____

_____

_____