Le Chateaux Rejuve Wellness

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Client Intake Form

Date:_____ Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip Code: _____ Phone: _____

Email:_____

Emergency Contact Name: _____ Phone: _____

How did you hear about us?: _____

General Health

Rate your level of stress (5= highest, 1= lowest) **5 4 3 2 1**

List your stress reduction activities: _____

Do you wear contact lenses? **YES NO**

Do you smoke? **YES NO**

Please list any accidents or surgeries in the last 9 months on the back of this page

Do you have any metal implants, a pacemaker or body piercings?

List the medications you are currently taking: _____

Massage Therapy

Have you ever had a professional massage before? **YES NO** If yes, when?_____

What type of pressure do you prefer?_____

Goal for your massage: **Relaxation Pain Relief Stress Relief**

Area of your body you do not want worked on? _____

Health History

Heart Condition	**Numbness**	**Rashes**	**Diabetes**	**Broken Bones**
Lymph Edema	**Sinus Problems**	**Jaw Pan/TMJ**	**Gas/Bloating**	
Pregnancy	**Herpes/Shingles**	**Allergies**	**Blood Clots**	
Headaches	**Fatigue/Sleep Disorders**		**High Blood Pressure**	
Chronic Pain	**Constipation**	**Arthritis**	**Depression/Anxiety**	
Low Blood Pressure	**Cancer**	**Varicose Veins**		
Sprains/Strains	**Spasms/Cramps**	**Arthritis**		

What is going on in your body?
Other: (List Of Surgeries)

_____

_____

_____

_____

_____

_____

_____

_____

Printed Name: _____ Signature: _____ Date:_____