

# Grateful Spirit Massage Client Intake Form

Name \_\_\_\_\_ Phone (     ) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ May I add you to my email list to receive newsletters and promotions? \_\_\_\_\_

Who may I thank for referring you? \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Please list your top 3 passions/hobbies \_\_\_\_\_

What are you grateful for? Please name 3: \_\_\_\_\_

Have you ever experienced a professional massage or bodywork session? Yes No How recently? \_\_\_\_\_

What massage or bodywork goals may I assist you with? \_\_\_\_\_

What kind of pressure do you prefer?  light  medium  firm

*If you answer "yes" to any of the following questions, please explain as clearly as possible.*

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?<br>Please specify _____        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis?                  |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses?                |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems?                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?               | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures?       | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area?                                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling?             | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any<br>medications I should know about? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases?           |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?                      | Comments _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies?                     |   |

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I affirm that I have stated all my own medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent to Treatment of Minor:** By my signature below, I hereby authorize Kristin Harrison, LMT to administer massage, bodywork techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_