Lauren Henderson Massage, LLC
Client Intake Form

Name:________________________________
Address:______________________________
City:______________ State:___ Zip:_______

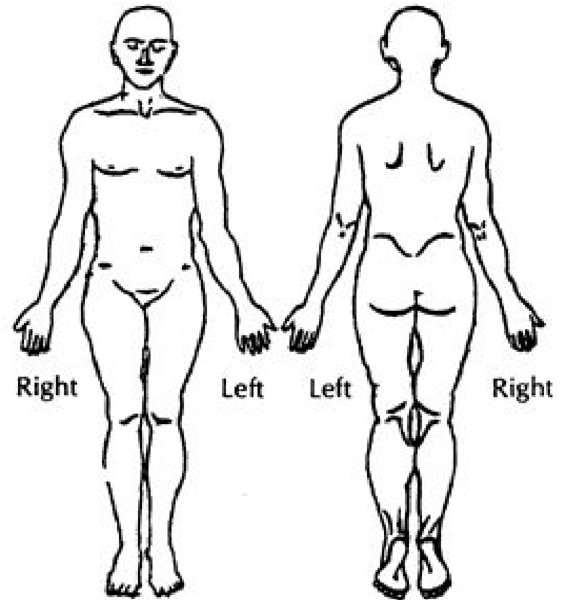
Phone:____________ Type: H:__ W:__ C:__
Email:_________________________________

Emergency Contact:______________________
Relationship:___________________________
Contact Phone:_________________________

D.O.B.:______________ Age:___________
Occupation:____________________________

Are you currently under physicians care? Y:___ N:___
If yes, for what?____________________________
Physician Name/Number:________________
____

Please circle to indicate any areas of pain or tension



Massage History

Have you ever received professional massage? Yes__ No__ If yes, date of last treatment:____________
What brought you here today for our services?
__Relaxation/Stress Relief __ Pain Management __Therapy __Other(specify):___________________
What results would you like to achieve today?____
Any areas specifically you'd like to focus on? Specify Here:_____________________________________
Any areas you wish **NOT** to be touched/massaged? Specify Here: _______________________________

Client Conditions

When did your symptoms start? ____
What other treatments have you received for your condition? (Check all that apply)
__ Medication __ Surgery __ Physical Therapy __ Chiropractic __ None __Other:____________
How often do you have this pain/tension?_____________ Does it come and go or is it constant?___________

Activities/Lifestyle:

Exercise:
__ None __ Daily
__ Moderate __ Heavy
Types of exercise you perform?
____
____

Work Activity:
__ Sitting __ Light Labor
__ Standing __Heavy Labor
Describe your work setting:
____
____

Lifestyle:
__ Smoking __Caffeine
__ Alcohol __ High Stress Level
How often is consumption?
____
____

Health History

Please check all conditions or symptoms you currently have or have had in the past:

__ Anemia	__ Cancer	__ Hepatitis	__ Multiple Sclerosis	__ Sinus Problems
__ Anorexia	__ Chemical Dependency	__ Hernia	__ Osteoporosis	__ Stroke
__ Appendicitis	__ Diabetes	__ Herniated Disc	__ Pacemaker	__ Tendonitis
__ Arthritis	__ Emphysema	__ Herpes	__ Parkinson’s Disease	__ Thyroid Problem
__ Asthma	__ Epilepsy	__ High Blood Pressure	__ Pinched Nerve	__ Tuberculosis
__ Blood Clots	__ Fibromyalgia	__ HIV/Aids	__ Pneumonia	__ Tumors/Growths
__ Breathing Difficulty	__ Fractures	__ Jaw Pain/TMJ	__ Polio	__ Ulcers
__ Bursitis	__ Glaucoma	__ Lymphedema	__ Prosthesis	__ Varicose Veins
__ Bronchitis	__ Head Injury	__ Migraines	__ Rheumatoid Arthritis	__ Whiplash
__ Bulimia	__ Heart Disease	__ Mononucleosis	__ Rheumatic Fever	__ Other ____________

Are you currently pregnant? Y __ N __ If yes, what’s your due date? ____________________

Please list any current medications or any vitamins/herbs/supplements and what you are taking them for:

____

____

____

Please list any other medical conditions, surgeries, accidents, and bone/joint/nerve/muscle injuries not listed above, and dates of incidents/diagnosis:

____

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____

Authorization/Informed Consent

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or incorrect information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my provider if I ever have any changes in health. I understand that massage therapy services are for the primary purpose of short-term relaxation and relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis, or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy is educational in nature and is to be used at my own discretion. I also understand that any illicit or sexually suggestive 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. Understanding all of this, I give my consent to receive care.

____ ________________________

Signature of Client, Parent, Guardian, or Personal Representative Date

____ ________________________

Printed Name of Client, Parent, Guardian, or Personal Representative Relationship to Client