**Heather Ziac**

**LMT**, **CPMT**, **CIMT**

**Massage Client Intake Form**

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| --- | --- |
| Name: Click or tap here to enter text. | Pronouns:Click or tap here to enter text. |

Address Click or tap here to enter text.

City Click or tap here to enter text.State Click or tap here to enter text. Zip Click or tap here to enter text.

Date of birth Click or tap to enter a date. OccupationClick or tap here to enter text.

Home phone Click or tap here to enter text.Cell phoneClick or tap here to enter text.

Email Click or tap here to enter text.

What is the best/preferred way of contacting you? Click or tap here to enter text.

Do I have permission to leave/send messages about appointments using the above? Click or tap here to enter text.

Emergency Contact name and relationship Click or tap here to enter text.

Emergency Contact phone Click or tap here to enter text.

How did you learn about me? Click or tap here to enter text.

What is your previous experience with Massage Therapy or Bodywork? Click or tap here to enter text.

Care Provider/Doctor Click or tap here to enter text.Telephone Click or tap here to enter text.

Do I have permission to communicate with your Care Provider if needed? Click or tap here to enter text.

Please mark if you have had or currently have the following:

anemia

bladder infection

blood clot or phlebitis \*

diabetes (gestational or mellitus)

edema/swelling

fatigue

headaches

insomnia

nausea

leg cramps

high blood pressure

low blood pressure

sciatica

varicose veins

visual disturbances

contagious conditions- please list Click or tap here to enter text.

skin condition- please list Click or tap here to enter text.

muscle sprain / strain

heart attack / stroke

arthritis

carpal tunnel syndrome

allergies- please list Click or tap here to enter text.

bursitis

hypo or hyperglycemia

contact lens

wig or hair piece

Have you had any serious or chronic illness, operations (including cesarean), or traumatic accidents?

If yes, please explain: Click or tap here to enter text.

Are there any areas in your body where you are feeling discomfort, tenderness, pain, numbness, tingling or any other symptom? If yes, please list or explain: Click or tap here to enter text.

Are you on any medication? Choose an item. If yes, which ones and what are they for? Click or tap here to enter text.

Do you exercise? If yes, what type?Click or tap here to enter text. Frequency and durationClick or tap here to enter text.

Any other general health, mental health, or anything else you think I should know about? Click or tap here to enter text.

I have completed this health form to the best of my knowledge. I understand that massage therapy is a health and wellness aid and does not take the place of a physician's care. Any information exchanged during a massage session is confidential and is only used to provide the best services for you.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 12 hours in advance. If I miss a scheduled appointment without giving 12 hour notice, I agree to pay any missed appointment charge.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_