Wild River MASSAGE STUDIO
Beth Dyer, LMT
Wildrivermassage.com

CLIENT INTAKE FORM

First Name____________________________

Last Name_____________________________

Phone_____________________________

Referred By_______________________________

Email
____

Mailing address___________________________

City_______________________________

State______________________________

Zip_______________________________

Emergency Contact
____

Emergency Phone #:____________________________

How would you rate your general health?

Excellent Good Fair Poor

Have you had a professional massage before? Yes No

List of current medications and medical conditions

List any major accidents or surgeries

underline any current or past problems:

HEAD AND NECK:

Headache/Migraine

Vision problem

Vertigo

Hearing loss

RESPIRATORY

Asthma

Chronic cough

Emphysema

Frequent colds

Shortness of Breath

Bronchitis

Smoker

NERVOUS SYSTEM

Sciatica

Seizures

Numbness/tingling

Epilepsy

Multiple Sclerosis

MUSCULOSKELETAL SYSTEM

Arthritis

Osteoporosis

Bursitis

Artificial joints/pins/plates

Tendonitis

TMJ/Jaw Pain

REPRODUCTIVE

Pregnant

Gynecological issues

Given birth

CARDIOVASCULAR

High Blood Pressure

Heart attack

Heart disease

Phlebitis

Hemophilia

Congestive Heart Failure

Low Blood Pressure

Stroke

Poor Circulation

Pacemaker

SKIN & INFECTION

Hepatitis

Herpes

Lyme Disease

HIV

Tuberculosis

Infectious Skin diseases

OTHER

Cancer

Fibromyalgia

Depression

Chronic Fatigue Syndrome

Digestive Conditions

Anxiety

It is my choice to receive massage therapy. I am aware of the benefits and risks and give my consent for massage. I have stated all my medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that all information provided and discussed will be kept confidential unless required by law.

____

Sign date