Natural Touch Client Intake Form

Contact Information

Name: _____ Phone (day): _____ Phone (eve):_____
Address: _____
City/State/Zip: _____
Email address: _____ Date of Birth: ____/____/____

Please provide the following information so you may receive the safest and most effective massage for you.

1. Have you had a professional massage before? Yes No
   If so, how often do you receive massage therapy? _____
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If so, please explain _____
3. Do you have any allergies to oils or lotions? Yes No
   If so, please explain _____
4. Do you have sensitive skin? Yes No
5. Do you sit for long hours at a computer or driving? Yes No
   If so, please explain _____
6. Do you experience stress in aspects of your life? Yes No
   If so, how do you think it has affected your health?
   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( )
7. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? Yes No
   If so, please explain _____
8. Do you have any particular goals in mind for this massage session? Yes No
   If so, please explain _____

Medical History

9. Are you currently under medical supervision? Yes No
   If so, please explain _____
10. Do you see a chiropractor? Yes No
    If yes, how often? _____
11. Are you currently taking any medication? Yes No
    If so, please list _____
12. Please check any condition listed below that applies to you:

( ) contagious skin condition	( ) swollen glands
( ) open sores or wounds	( ) circulatory disorder
( ) easy bruising	( ) allergies/sensitivity
( ) recent accident or injury	( ) heart condition
( ) recent fracture	( ) high or low blood pressure
( ) recent surgery	( ) swollen glands
( ) artificial joint	( ) epilepsy
( ) sprains/strains	( )headaches/migraines