

Client Intake Form

Joel Rayburn LMT

407-422-5666

Name _____

Address _____

City _____ State _____ Zip _____

Contact phone _____ Email address _____

Height: _____ Weight: _____ Birth Date: _____

Profession _____

Referred by _____

Physician's Name _____ Physician's Phone _____

Current Health

Do you exercise regularly and/or participate in any sports? Yes No
If yes, which sports? _____

Have you recently suffered an injury? Yes No
If yes, describe: _____

Have you had any areas of inflammation? Yes No
If yes, describe: _____

Are you currently under the care of a physician? Yes No
If yes, explain: _____

Have you had recent surgery? Yes No
If yes, explain: _____

Medications/Allergies: _____

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Name _____ Date _____

Massage Experience

Have you had a professional massage before? Yes No

What types of massage/bodywork have you had? _____

How long have you been receiving massage therapy? _____

Frequency of treatments? _____

What are your goals for treatment? _____

Health History (Circle one option per item)

- | | | | |
|-----------------------|----------|----------------------------|---------|
| Contact lenses | Yes No | High blood pressure | Yes No |
| Dentures | Yes No | Low blood pressure | Yes No |
| Back pain/Sciatica | Yes No | Ulcer | Yes No |
| Spinal problems | Yes No | Tendonitis, bursitis, etc | Yes No |
| Osteoporosis | Yes No | Arthritis or joint disease | Yes No |
| Broken bones | Yes No | Diabetes | Yes No |
| Easy bruising | Yes No | Seizures/Convulsions | Yes No |
| Skin problems | Yes No | Multiple Sclerosis | Yes No |
| Allergies | Yes No | Nerve degeneration | Yes No |
| Varicose veins | Yes No | Cancer or tumors | Yes No |
| Phlebitis/Blood clots | Yes No | Infectious diseases | Yes No |
| Heart problems | Yes No | | Yes/No |

Any other medical condition(s) the therapist should be aware of? _____

Signature _____ Date _____

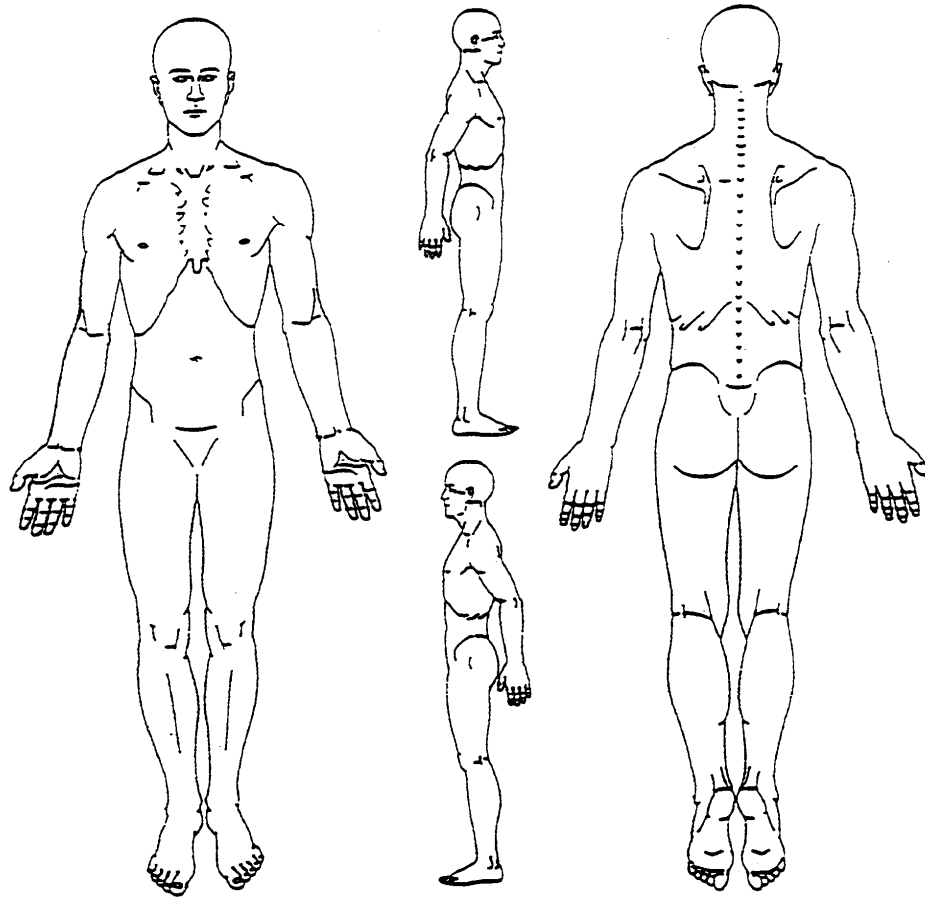
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Name _____

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Please mark painful areas.