

Client Intake Form

MassageWorks Port Aransas

Full Name: _____ DOB: _____

Address: _____ City, State, Zip _____

Phone #: _____ Email: _____

Occupation: _____ Other Activities _____

Emergency Contact: _____ Phone #: _____

Physician: _____ Phone #: _____

Medications Being Taken _____

Please indicate any of the following conditions that you currently have:

- varicose veins blood clots headaches allergies arthritis, tendonitis
- cancer TMJ abnormal skin condition varicose veins blood clots
- heart/circulation problems joint surgery high / low blood pressure
- neck / back injuries diabetes fibromyalgia numbness sprains, strains recent injuries

Explain Any Conditions You Have Marked Above:

Areas of Complaint, Pain or Tension: _____

Have you had massage therapy before? _____ Was it helpful? _____

How did you find out about this service? _____

Please circle areas you wish to be avoided:
head shoulders face back feet upper chest
hands buttocks neck abdomen legs arms

I have completed this information form to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated. Information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

If I am uncomfortable for any reason, I may ask to end the session.

Client Signature: Date: