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Confidential Client Intake Form

Full Name:		Date of Birth:
Address:		
City:	State:	Zip:
Phone: (h)	_ (c)	Email:
Occupation:		
How did you hear about Power M	Aassage?	1 LYON
Emergency Contact:		Phone:
Relationship:		
Primary Care Physician:		Phone:
Medications (including vitamins/herbs):		
Please check if you have or have had any of the following:		
 Headaches Cancer Heart/circulation problems Major accident Neck/back injuries 	 allergies TMJ joint surgery varicose veins diabetes 	 arthritis/tendonitis abnormal skin condition high/low blood pressure blood clots fibromyalgia
□ Numbness/tingling	□ sprains/strains	\Box recent injuries
Explain any conditions marked above:		

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination; rather, it is a form of health promotion utilizing various techniques and modalities. I take responsibility for alerting my therapist to any physical, mental or emotional changes that could affect this work.

Signature: _____

Date: _____