Soul Touch Therapies

Massage Client Intake Form

PLEASE PRINT LEGIBLY

Name _____ Email _____
Address _____ City/State/Zip _____
Phone: Home_____Work_____Cell_____ Birthday ___/___/___
Occupation _____ Referred to This Office By _____
In Case of Emergency Please Contact _____Phone_____

General and Medical Information

Y N Have you ever had a professional massage? If yes, how often? _____

Y N Are you pregnant? If yes, how far along are you? _____

Y N Are you sensitive to touch/pressure in any area? (ticklish?) _____

Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:

_____

List of current medications and reason: _____

_____

_____

List of surgeries (type and date): _____

_____

_____

Indicate Areas of Pain/Tension:

On a scale from 1-10, 10=highest, rate your levels of:
Stress ___ Pain ___ Energy ___
How did your symptoms begin and when did they start?

_____

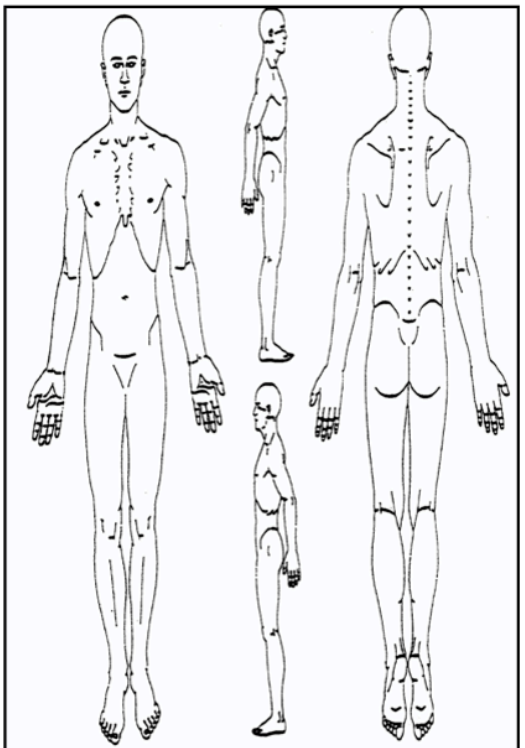
_____

What have you done for relief? _____

Is the condition getting better/worse? _____

Please check all that apply:

- ❑ Skin condition-rash, warts, hives, skin cancer, other _____
- ❑ Lymphatic condition-swollen gland, nasal congestion, lymph edema
- ❑ Joint problems/stiffness-arthritis, sacroiliac problems, TMJ, other
- ❑ Bone Condition-osteoporosis, fracture, other _____
- ❑ Headaches
- ❑ Recent injury or accident-whiplash, sprain, bruise, other _____
- ❑ Circulatory Condition-high blood pressure, varicose veins, blood clots
- ❑ Numbness/Tingling, Sciatica
- ❑ Tendonitis, Bursitis
- ❑ Diabetes



Please mark in the diagram above any areas where you have pain or discomfort.