A STEP BEYOND MASSAGE THERAPY

Client Intake Form

Name_____ Date_____

Are you wearing any face or eye makeup? Yes No

If this is a return visit, have any of these conditions changed since your last massage?

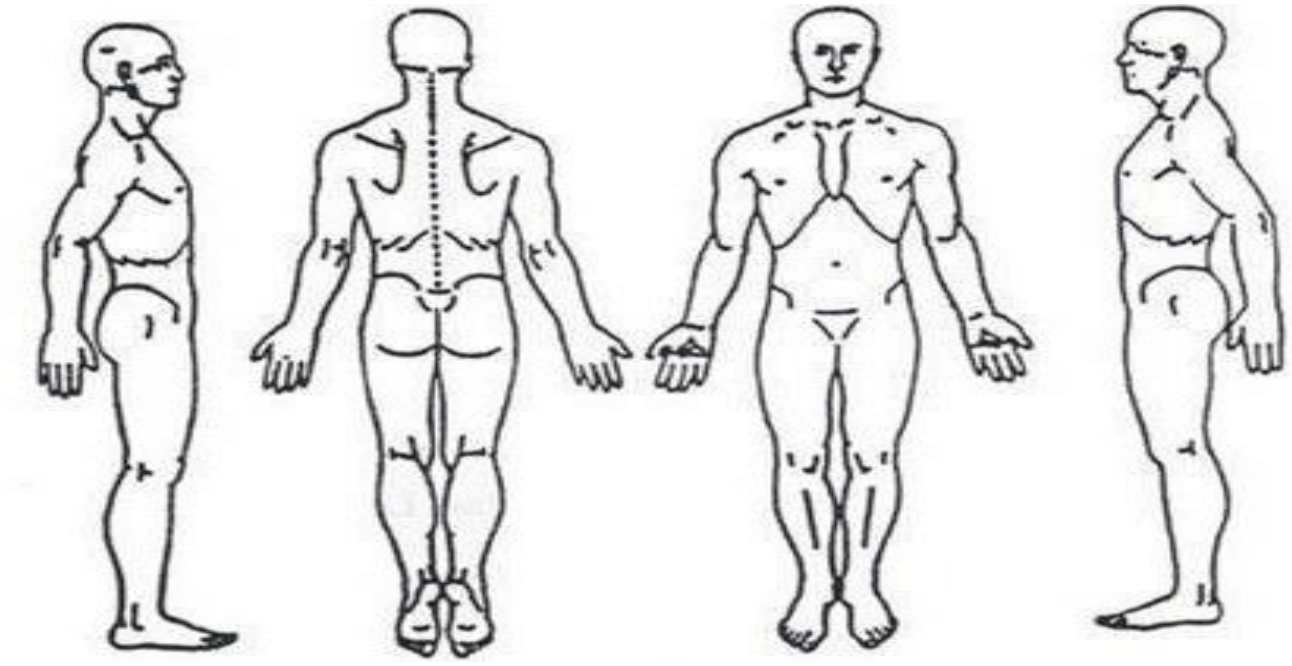
- □ Alcohol use
- □ Arthritis
- □ Asthma
- □ Bruise easily / Current Bruises
- □ Cancer / Tumors
- □ Diabetes
- □ Drug use
- □ Edema
- □ Epilepsy
- □ Fever
- □ Fibromyalgia
- □ Fractures
- □ Headaches
- □ Heart attack / Pace maker
- □ Heart disease
- □ High blood pressure
- □ Illness / Disease
- □ Insomnia
- □ Localized Infections
- □ Low blood pressure
- □ Medications
- □ Open Wounds
- □ Pacemaker
- □ Painful joints / Bursitis
- □ Painful menstruation
- □ Phlebitis / Thrombosis
- □ Poor circulation
- □ Pregnancy _____months
- □ Sinus infection
- □ Skin Irritation / Rash
- □ Skin conditions / Skin Diseases
- □ Smoking
- □ Stroke
- □ Swelling
- □ TMJ
- □ Varicose veins
- □ **Nut Allergies**
- □ **Other Allergies**

If you checked any of the above conditions or if you have a condition not listed above, please explain:

_____

_____

Please circle areas on the diagram below that you feel need extra work. Cross out any areas you would like to be avoided.



Preferred Pressure (circle one): **Light** **Medium** **Deep** **???**

Signature: _____

*Payment is confirmation of satisfactory service.