CLIENT INTAKE FORM

PERSONAL INFORMATION DATE:

Name:			Male / Female	Referred By:		
Height:	Weight:	DOB:	Phone (h):	(w):	(c):	
Address:			E-Mail:			
City:	State:	Zip:	Occupation:			
Emergency Contact:			Relationship:	Phone:		

Please answer the following questions to the best of your knowledge as they will be used to help plan safe and effective PNMT sessions.

Have you had a professional massage before? Yes / No
If yes, how often do you receive massage therapy? _____

Do you have any difficulty lying on your front, back, or side? Yes / No
If yes, please explain: _____

Do you have any allergies to oils or lotions? Yes / No
If yes, please explain: _____

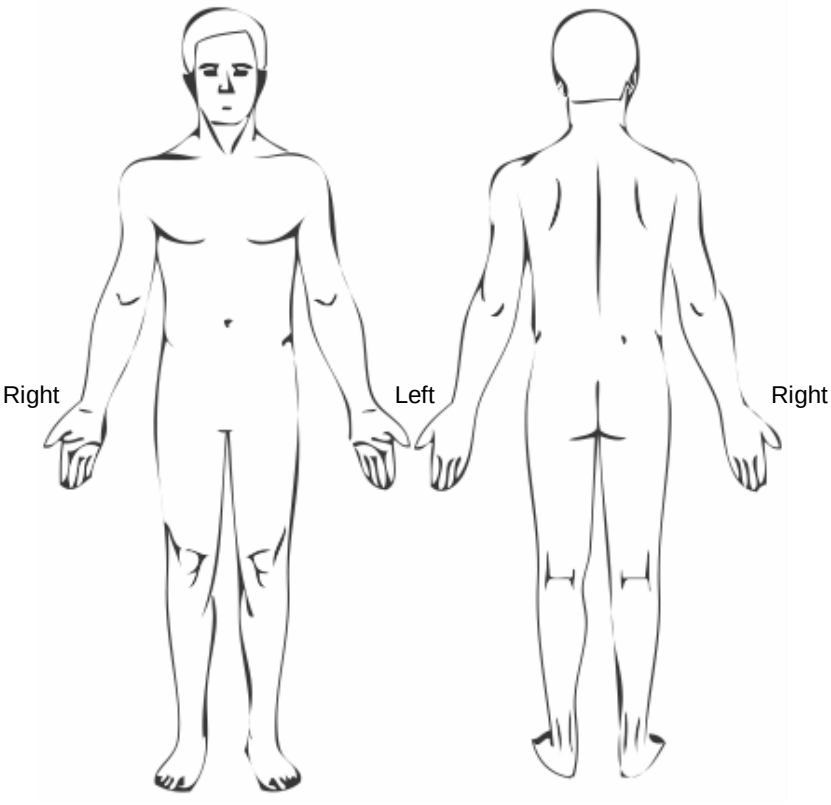
Are there certain area(s) of your body that you would like avoided? Yes / No
If yes, please explain: _____

Do you sit for long hours at a workstation, computer, or while driving? Yes / No
If yes, please describe: _____

Do you perform any repetitive movements in your work, sports, or hobby? Yes / No
If yes, please describe: _____

Are there particular area(s) of the body where you are experiencing pain or other discomforts? Yes / No
If yes, please identify: _____
_____
_____

* Please mark the areas where you experience pain.



MEDICAL HISTORY

Are you currently under medical supervision? Y or N
If yes, please explain: _____

Do you see a chiropractor? Y or N
If yes, how often: _____

Are you currently taking any medication? Y or N
If yes, please list: _____

Please check any conditions listed below that apply to you:

MUSCULO-SKELETAL
__ Headaches
__ Joint stiffness/swelling
__ Spasms/cramps
__ Back/hip pain
__ Shoulder/neck/arm/hand pain
__ Leg/foot pain
__ Chest/ribs/abdominal pain
__ Problems walking
__ TMJ/jaw pain
__ Tendonitis
__ Bursitis
__ Arthritis
__ Osteoporosis
__ Scoliosis
__ Bone or joint pain
__ Broken/fractured bones

CIRCULATORY/RESPIRATORY
__ Dizziness
__ Shortness of breath
__ Fainting
__ Cold feet or hands
__ Swollen ankles
__ Varicose veins
__ Blood clots
__ Stroke
__ Heart condition
__ Allergies
__ Sinus problems
__ Asthma
__ High blood pressure
__ Low blood pressure
__ Lymphedema

NERVOUS SYSTEM
__ Numbness//tingling
__ Chronic pain
__ Ulcers
__ Paralysis
__ Epilepsy
__ Chronic Fatigue
__ Multiple Sclerosis
__ Muscular Dystrophy
__ Parkinson's
__ Spinal cord injury

SKIN
__ Rashes
__ Warts
__ Athlete's Foot

DIGESTIVE
__ Constipation
__ Diverticulitis
__ IBS
__ Crohn's Disease

OTHER
__ Depression
__ Pregnant
__ Menopause
__ Diabetes
__ Fibromyalgia
__ Cancer

Is there anything else about your health history that you think would be useful for your massage practitioner to know in order to plan a safe and effective massage for you? _____

_____

_____

_____

I, _____, understand that the massage I receive is provided using the Precision Neuromuscular Therapy modality. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I also agree that if I fail to show up for an appointment or do not cancel said appointment within 36 hours, and the therapist is unable to fill the time-slot, I will be expected to pay for the session.

Signature of Client: _____ Date: _____