

**MASSAGES INC. BY L. CURE -
MESSAGE CLIENT INTAKE SHEET**

Name: _____ Date: _____
Address: _____ City/State/Zip: _____
Phone: _____ Work: _____ Occupation: _____
Emergency Contact: _____ Phone: _____
Birth date: _____ Referred by: _____

Please mark any of the following conditions you may currently have:

- | | | |
|--------------------------------------------|----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Wear contacts | <input type="checkbox"/> Cold virus | <input type="checkbox"/> Neck Injury |
| <input type="checkbox"/> Open Wounds | <input type="checkbox"/> Alcohol w/in 24 hrs | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Flu | <input type="checkbox"/> P.M.S. |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Kidney Ailment | <input type="checkbox"/> Emotional changes |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Fever w/in 24 hrs | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Recent Surgery | <input type="checkbox"/> Bruises | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Grief process | <input type="checkbox"/> High blood Pressure | |
| <input type="checkbox"/> Acute pain | <input type="checkbox"/> Varicose vein | |

Please list all accidents where an injury(ies) occurred and all surgeries within the past five (5) years. In addition list anything else you want me to know about your health history and current condition(s) before proceeding with your massage therapy:

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnosis illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perform spinal manipulations.

I understand that massage therapist is not a substitute for medical examination and/or diagnosis. I will inform the therapist of my current condition at the time of each visit.

Client Signature: _____

**PLEASE GIVE A 24-HOUR NOTICE IF YOU CANNOT KEEP YOUR
APPOINTMENT!!! Thank you for your consideration.**