Integrative Manual Therapies, LLC

Client Intake Form

Name (full name, as listed on drivers license)	Last		How did you hear about us?
	First		List your goal for this visit:
Email (news,coupons)			History of injuries, illnesses and/or surgeries:
Phone	Home		
	Mobile		
Address	Street		List regular physical activities/sports:
	City		Circle any of the following that you have had within the past year:
	State		
	Zip		
DOB	**Height**	**Weight**	
Present Medications:			
Family or General Physician:			
Specialist:			

Pain:

Headaches, Shoulder, Back, Neck, Chest, Arm, Abdomen, Pelvis, Hip, Groin, Leg, Buttock

Disorders:

Digestion, Cramps, Seizures, Asthma, Fibromyalgia/CFS, Scoliosis, Depression, Anxiety

Other:

Signature: _____

Date: _____

I understand that the massage therapy given here 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 diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for maedical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.