

Confidential Client Intake Information

(Please print clearly)

Name: _____ M/F: _____

Reason for Appointment: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (H) _____ (W) _____ (C) _____

Occupation: _____ Date of Birth: _____

Emergency Contact Person: _____ Phone #: _____

How were you referred or whom can we thank? _____

E-mail address: _____

(E-mail addresses are for the sole use of Kenny Lyons LMT. They will not be shared with any third parties)

Have you had a professional massage before? Yes No

Female clients only. Are you pregnant or do you think you might be pregnant? Yes No

Medical History. Please check if applicable:

<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Peripheral Neuritis
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Bruises	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Asthma
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Anemia	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Osteoporosis/osteomalacia
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Stroke/Heart Attack	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lupus
<input type="checkbox"/> Leg/Foot Pain	<input type="checkbox"/> Spinal Problems	<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Edema
<input type="checkbox"/> Arm/Hand Pain	<input type="checkbox"/> Varicose/Spider Veins	<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Constipation
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Fever	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Dentures

Any Injury/Trauma (date/brief description): _____

Any Auto Collision (date/brief description): _____

Please list all health care practitioners, doctors, and chiropractors:

Name _____ Phone# _____

Name _____ Phone# _____

If any contraindications are present, may I consult with your physician? Yes No (check one)

Please list all surgeries: _____

Please list all medications currently being taken and conditions being treated: _____

I understand that 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. It has been made very clear to me that massage is not a substitute for medical exams and/or diagnosis and that is recommended that I see a physician for any physical problem that I might have.

Because the 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.

There is no charge for appointments cancelled and rescheduled at least 24 hours before appointment time. You will be charged the full amount for failing to show up for a scheduled appointment.

I understand that my records are protected under federal and state regulations and cannot be disclosed without my express written consent.

Name: _____ Date: _____