



Client Intake Form

Carole Lilly, LMBT NC #7803

Kindly give 24 hours cancellation notice to avoid being charged.

Please fill in the form below. The information will be kept completely confidential and helps provide the safest and most effective treatment.

Name: _____ Date: _____ Date of Birth: _____

Address: _____ May I send you mail? Yes | No

Phone: _____ Cell: _____ May I leave you a phone message? Yes | No

Email: _____ How did you hear about me? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Current Health:

Have you ever received massage therapy before? _____ How often? _____

What type of massage pressure do you prefer? Light | Medium | Deep

Today's primary goal: Relax | Pain Relief | Other: _____

Classify pain/other: Minor _____ Problematic _____ Major _____

Classify type: Recurring/Chronic _____ Getting Worse _____ Getting Better _____

Have you received treatment for this before? Yes ___ No ___ Explain: _____

Exercise activities: _____ Frequency: _____

Current Medications: _____

Check any of the following that apply to your current health:

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies/Sensitivities | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Skin/Fungal Conditions |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Circulatory Conditions | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Health Issues | |

Comments: _____

Check any body parts (besides genitals and breasts) where you do NOT want to receive massage:

- Abdomen/Stomach ___ Arms ___ Buttocks ___
 Chest ___ Face ___ Feet ___ Head ___
 Hands ___ Legs ___ Other ___

Previous History:

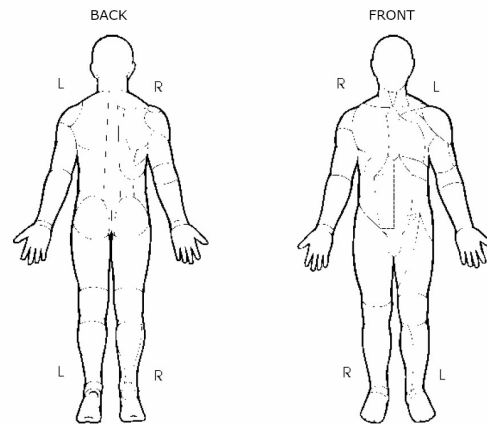
List in chronological order, stating dates or ages and treatment received:

Surgeries: _____

Accidents: _____

Major Illnesses: _____

Mark on figures all areas of pain, tenderness, numbness, stiffness, and swelling:



I have completed this form to the best of my knowledge. I agree to keep the practitioner updated as to any changes in my medical profile.

Signature: _____

Date: _____