Santa Fe Massage Therapy Bob Grejdus, B.S., L.M.T.

Client Intake Form

Name: _____ **Date:** _____

Address: _____

Phone numbers: (Cell)_____ **(Home)**_____

Email: _____ **Date of Birth:** ____/_____/_____

Current Occupation: _____ **How did you hear about me?** _____

Preferred method of contact (circle one): text call cell email call home other:_____

**** If client is under 18 yr or unable to decide for themselves,*** *a parent or legal guardian for the client is giving informed consent for the client to receive massage by signing below.* **Please print name, sign & date:**

_____

Please review the following list and check anything that might be relevant to you:

___ Arthritis ___ Auto-Immune Condition _____ ___ Cancer

___ Chronic Pain: _____ ___ Diabetes ___ Fibromyalgia

___ High Blood Pressure ___ Osteopenia / Osteoporosis ___ Scoliosis

___ Skin Condition: _____ ___ Unexplained discomfort or pain ___ Varicose Veins

___ Medication that inhibits blood clotting ("blood thinner")

___ Allergies: _____

Have you recently had an injury, surgery, or areas of inflammation? If yes, please describe.

_____

Do you exercise regularly and/or participate in any sports? If yes, what kind and how frequent?

_____

How are you feeling in your body today? _____

On the diagrams, please indicate any areas in which you are currently feeling discomfort.