Battle Ready
BODYWORK

Client Intake Form

Name: _____ Gender: ○ Male ○ Female

Date of Birth: _____ Current MOS: _____

Address: _____ Phone: _____

_____ Email: _____

Doctor/PCM: _____ Referred by: _____

List some of your regular activities including hobbies & sports: _____

_____

Is this your first time getting a massage? ○ Yes ○ No

What is your main reason for seeking massage? _____

How would you describe your health? Excellent

Are you currently under the care of a physician, physical therapist, chiropractor or other

health care provider for any medical condition? ○ Yes ○ No

If yes, please explain: _____

Do you have a (temporary/permanent) profile? ○ Yes ○ No

If yes, please explain: _____

Are you currently taking medication? ○ Yes ○ No

If yes, please list medications: _____

Do you have any allergies or skin sensitivities? ○ Yes ○ No

If yes, please explain: _____

Check all that apply:

☐ High levels of stress	☐ Tobacco use	☐ Tendonitis	☐ Sciatica
☐ Anxiety	☐ Contagious skin condition	☐ Carpal tunnel	☐ TMJD
☐ Depressed mood	☐ Open sores or wound	☐ Knee problems	☐ Diabetes
☐ Touble sleeping	☐ Bruise easily	☐ Tennis/golf elbow	☐ High/low BP
☐ PTSD	☐ Recent injury (< 3 months)	☐ Frozen shoulder	☐ Pregnant
☐ Migraines	☐ Sprains/strains	☐ Other:	

I understand that my therapist needs to be fully aware of my existing medical conditions in order to massage me safely and effectively.
I have completed this form to the best of my ability and will inform my therapist right away if anything changes in my medical history.
I understand that if I have a serious medical diagnosis, I must provide a physician's written consent prior to treatment.

_____
Client Signature Date