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Bryn Karlberg
Licensed Massage Practitioner

CLIENT INTAKE FORM

Name: _____ DOB: _____

Address: _____

Telephone (Home): _____ (Cell): _____ (Work): _____

Emergency Contact Person: _____ Telephone: _____

Who may I thank for referring you today? _____

Insurance company: _____ Policy No.: _____ Group: _____

Have you ever had a massage before: ○ Yes ○ No
If yes, how long ago? _____

Are you currently under a physician's care for any condition? ○ Yes ○ No
If yes, please describe: _____

Physician: _____ Telephone: _____

Primary reason for visit today: _____

Areas of complaint, pain and/or tension: _____

Please answer the following questions by circling the appropriate answer:

○ Yes ○ No Do you wear contact lenses?
○ Yes ○ No Do you wear dentures?
○ Yes ○ No Do you have any allergies?
○ Yes ○ No Do you have arthritis?
○ Yes ○ No Do you have any heart problems?
○ Yes ○ No Are you HIV positive?
○ Yes ○ No Do you have spinal problems?
○ Yes ○ No Are you pregnant?

Yes No Do you have varicose veins or blood clots? _____

Yes No Do you have any problems with blood pressure?

If yes, what type?_____

Yes No Do you have any skin problems, diseases or open sores?

If yes, where? _____

Yes No Have you ever had surgery?

If yes, please describe: _____

Yes No Do you take any prescribed medications?

If yes, please describe:_____

Yes No Have you suffered an acute (recent) injury?

If yes, please describe:_____

Yes No Do you exercise or play sports on a regular basis?

If yes, please describe: _____

What is your predominant sleeping position (stomach, side, back)? _____

Do you wake in the morning feeling rested? _____

How many hours a day do you sit during a work day (including drive time)?: _____

PLEASE READ AND INITIAL IN THE PROVIDED SPACE THAT YOU HAVE DONE SO:

_____ I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and energy flow.

_____ I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. In addition, the massage therapist does not prescribe medical treatment or pharmaceuticals nor does he/she perform any spinal manipulations.

_____ It is understood that any illicit or sexually suggestive remarks or advances on my part will result in immediate termination of the massage session, and I will be liable for payment of the full scheduled appointment.

_____ It has been made very clear to me that massage therapy is not a substitute for medical 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.

Signature: _____ Date: _____

I have completed the information accurately and have read and understand the above statements.