

# Full Throttle Massage, Inc.

## Client Intake Form

Name: \_\_\_\_\_ Phone # (     ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

May we contact you, by phone and/ or Email, for scheduling and/ or special promotions? Circle one:    Yes     No

In Case Of Emergency \_\_\_\_\_ Phone # \_\_\_\_\_

How did you find us?    Internet \_\_\_    Radio \_\_\_    Print Ad \_\_\_    Other: \_\_\_\_\_

Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_    Do you have children? Circle one: Yes    No    If yes, how many? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Have you ever had a professional massage? Circle one: Yes    No    If Yes, Approximately How Many? \_\_\_\_\_

Do you wear contacts? Circle one:    Yes    No

Are you pregnant or trying to get pregnant? (females only) Circle one:    Yes    No    If yes, what trimester? \_\_\_\_\_

Have you had any recent illness, injuries or surgeries? Circle one:    Yes    No

    If yes, please explain: \_\_\_\_\_

Do you have any areas of concern (ex: back pain) \_\_\_\_\_

When did you first notice it? \_\_\_\_\_ What brought it on? \_\_\_\_\_

What activities aggravate the condition? \_\_\_\_\_

What have you done to get relief? \_\_\_\_\_

Has there been a medical diagnosis? Circle one:    Yes    No

    If so, by whom? \_\_\_\_\_

List any medications (including aspirin) and nutritional supplements you are taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your expectations regarding this massage? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_