Lacey Massage Therapy, PLLC
Client Intake - Confidential Information

Name: _____ Birthdate: _____

Address: _____ Home Phone: _____

City: _____ Work Phone: _____

State: _____ Zip: _____ Cell Phone: _____

Email: _____ OK to contact: YES_____ NO_____

Occupation: _____ Referred by: _____

Emergency Contact (Name & phone #): _____

Reason for your visit today, and the results that you want: _____

_____

_____

Do you have any of the following today?

___Sunburn ___Inflammation ___Cold/flu ___Severe pain ___Headache
___Open cuts, bruises, burns ___Irritated skin rash ___ Contagious Disease/Infection

YES NO Have you ever had a professional massage?
Approximate date of last massage:
How frequently do you receive massage?

YES NO Do you have any recent injuries, illnesses or surgeries that are still affecting you?

YES NO Are you currently under the care of a healthcare provider for a specific condition?

YES NO Do you have any allergies to different scents or oils?

YES NO History of blood clots?

YES NO History of cancer? What type?

YES NO Are you pregnant? If so... How far along?_____ Any history of difficult pregnancies? _____

I understand that massage practitioners do not diagnose any conditions, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations.

I have stated all medical conditions that I am aware of and will keep the massage practitioner informed of any changes in my health status.

I have read and agree to the Office Policies.

Signature:_____

Date:_____