CONFIDENTIAL CLIENT INTAKE FORM

Colleen Casey, Registered Massage Therapist, Certified Fascial Stretch Therapist

Name_______________________________________________ Date of Birth ____________________

Address____________________________________ City, State, Zip _______________________________

Employer _______________ Occupation ______________________ Last professional massage (date) ____

How did you hear about me? __________________________________________ (friend, doctor, Yelp, etc).

Please list any condition that you have now (tendinitis, etc): ___________________________________________

Are you currently receiving treatment for this? _____________________________________________________

Specific goals for today's session:_________________________________________________________________

| List any injury, surgery or car accident | Date | What treatment did you receive? | Any current pain or limitations? |
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Are there any areas you prefer NOT to have massaged? ____ If yes where and why________________________

List weekly physical activities_________________________________________________________________

List current medications and frequency ________________________________________________________

I understand that a massage therapist must be aware of any and all existing physical conditions that I have (including high blood pressure) in order to provide appropriate treatment.

I further understand that a massage therapist neither diagnoses nor prescribes for illness, disease, or any other medical, physical or emotional disorder, nor performs spinal adjustments or manipulations. I am responsible for consulting a qualified primary care provider for any physical ailment that I may have.

**CANCELATION POLICY – Please contact me at 206.719.1366 within 24 hours of your appointment or you may be charged the full price of your session.**

Signed ______________________________________________ Date_____________________________