

Loveland Orthopedic Massage Therapy

Client Intake Form

Name: _____ Birth date: ___/___/___

Street: _____ City: _____ Zip: _____

Phone: _____ Cell _____ wk: _____

Email: _____

How did you find out about me? _____

The form below is a to give me an idea of where to start. Please feel free to elaborate verbally during your session. Often people will have several goals or concerns.

What are you looking for from your work with me?

Are you currently receiving any other care? If so please describe:

Do you have any injuries or conditions that might require special care or caution?

Do you have any communicable diseases? If so please describe:

Are you allergic to any oils, particularly peanut, grape seed or almond? Yes No

Is there anything else that you feel is important for me to know?

Do you have any questions or concerns about the work I do?

Thank you for taking the time to fill out this form. As I stated above we will periodically reassess our work together. Please keep me informed as to any changes in your health or other care you are receiving.

Print Name: _____ Signature: _____ Date ___/___/___.

If under 18 this form must be accompanied by a Minor Consent Form:

Guardian Name: _____ Signature: _____ Date ___/___/___