STEP ABOVE MASSAGE

Client Intake Form

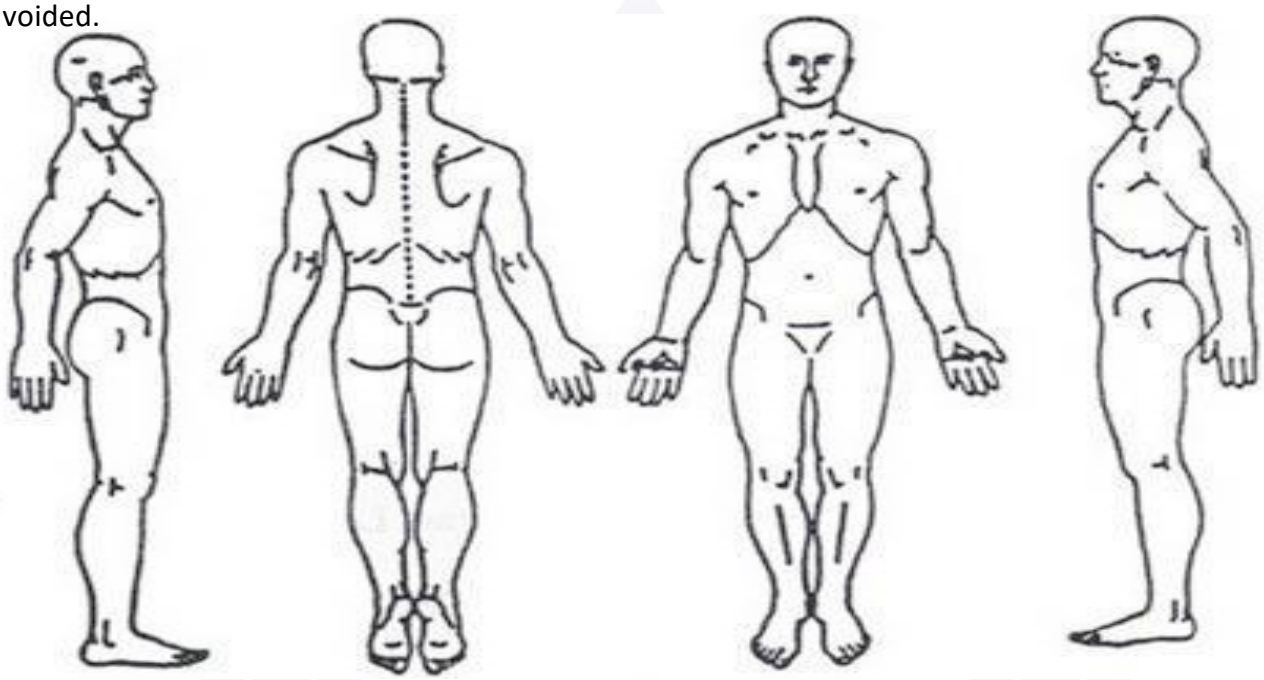
Name_____
Date_____
Are any of your joints painful when moving them? Yes No
If yes, please
explain_____

If this is a return visit, have any of these conditions changed since your last massage?

- □ High blood pressure
- □ Pregnancy / painful menstration
- □ Thrombosis/Phlebitis
- □ Localized infections/ open wounds
- □ Fracture(s) / painful joints
- □ Skin problems / rash
- □ Headaches
- □ Trauma / wounds
- □ Varicose veins
- □ Bruising
- □ Swelling
- □ Fever
- □ Medications
- □ Illness / Diseases
- □ Injuries
- □ Nut Allergy

If you checked any of the above conditions or if you have a condition not listed above, please explain:
_____
_____
_____

Please circle areas on the diagram below that you feel need extra work. Cross out any areas you would like to be avoided.



Preferred Pressure (circle one): Light Medium Deep ???

Signature: _____