Julie Bittel, LMT
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CLIENT HEALTH INTAKE FORM:

Name ____ Today's Date _____________________

Address____ Date of Birth ______________________

____ Occupation ______________________

Phone Daytime ________________________________Evening___________________________________

Email____Is it okay to contact you via email? ___________

In case of emergency contact________________________________phone____________________

Primary Healthcare Professional:

Name____phone____________________

Name____phone____________________

Other Therapies you are currently involved:

____Acupuncture/Acupressure ____Chiropractic ____Emotional ____ Herbalist ____Nutrition

____Physical Therapy ____ M.D./D.O. ____Naturopathy ____ Other explain______________________

Medications you are currently taking and for what:

1.____ 2. ____

3.____ 4. ____

Current Conditions:

____Allergies - see below	_______Contacts	_______High/Low Bld pressure
____Arthritis	_______Diabetes	_______Numbness/pain
____Blood Clots	_______Dentures	_______Pregnant: Mos_____
____Bruises	_______Depression	_______Osteoporosis
____Bursitis	_______Epilepsy/seizures	_______Sprains/Strains
____Cancer/Tumors	_______Fatigue	_______Sleep Difficulty
____Clenching teeth	_______Fibromyalgia	_______Varicose veins

Do you suffer from Chronic Headaches? ________ Chronic Backaches __________

List any contagious diseases: ____

List any allergies or skin problems: ____

Broken bones, surgery, whiplash or traumas:____

____

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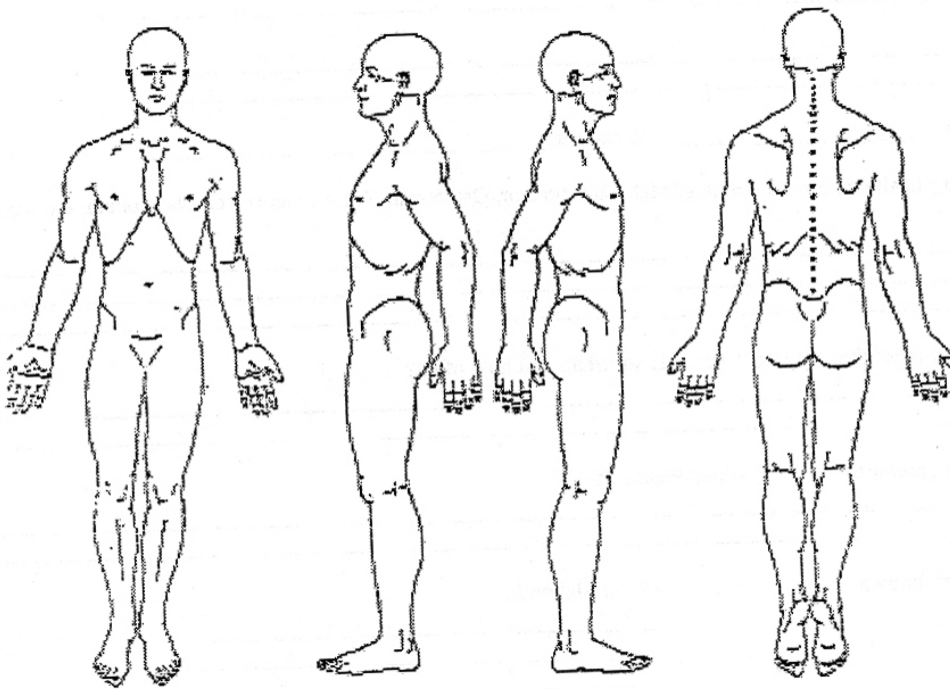
Exercise Habits: ____

Dietary Habits: ____

Have you ever had a massage? _____Yes _____No If yes, how long ago? ____________________________

Reason for getting a massage today:____

Below, please circle areas that correspond to the places where you hold stress and/or tension and where you may be currently experiencing pain:



Please add anything else that your therapist should know before starting your massage: ___________________

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