Liam Bowler, LMP (MA60160115) Date _____

New Client Intake Form

About you ...

Name _____ Date of birth _____

Occupation _____

Best way to contact you _____

Emergency contact (name and number) _____

Please provide any of the following to be updated on my practice, including seasonal specials. I'll never give, trade or sell any of your information away, promise.

Address (include city, state, zip): _____

_____

Email: _____ Phone: _____

Have you received massage therapy before? *Yes* *No*

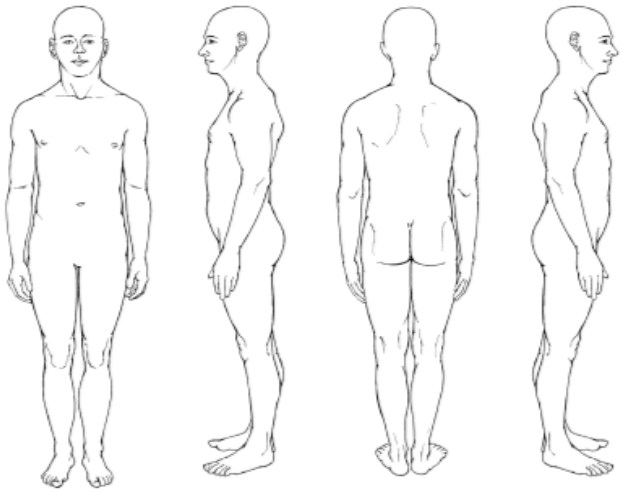
Do you have any difficulty lying on your front, back, or side? *Yes* *No*

Has your skin ever reacted to any oil, cream, lotion or ointment? *Yes* *No*
If yes, please tell me more.

Please give me a short explanation of what you do at work (focusing on your physical body).

About what brings you here today ...

Do you have any particular goals for our session(s) together? If yes, what are they?



Using these body images, please identify areas of pain, tension, numbness, or that you'd just like me to focus on today.

(please complete the other side, too)

Your medical condition and history ...

What medications, if any, are you taking? Please include herbs and supplements.

Please check any condition listed below that applies to you.

( ) allergies/sensitivity
( ) artificial joint
( ) atherosclerosis
( ) back/neck problems
( ) cancer
( ) carpal tunnel syndrome
( ) circulatory disorder
( ) contagious skin condition
( ) current fever
( ) decreased sensation
( ) deep vein thrombosis/blood clots
( ) diabetes
( ) easy bruising
( ) epilepsy
( ) fibromyalgia
( ) headaches/migraines
( ) heart condition
( ) high or low blood pressure
( ) open sores or wounds
( ) osteoarthritis
( ) osteoporosis
( ) phlebitis
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) rheumatoid arthritis or any joint disorder
( ) sprains/strains
( ) swollen glands
( ) tendonitis or tendonosis
( ) tennis elbow
( ) TMJ disorder
( ) varicose veins

Please explain any condition you marked above.

Is there anything else about your health history that would be useful for me to know in order to plan a safe and effective treatment for you?

Please let me know if any of the following apply to you from this point on:

- You experience pain or discomfort (beyond what you deem acceptable) during the session
- You have questions about your treatment—what I'm doing and why—at any time
- Your medical condition (i.e. what you've filled out on this form) changes in any way

To your health! Your signature below states that you agree to the above.

You _____ Date _____

Me _____ Date _____