The Art of Health, LLC • 2055 N. 15th St. Ste. 201 • Arlington, VA 22201 • Ph. (703) 340-4325

MASSAGE CLIENT INTAKE FORM

PERSONAL INFORMATION

Name: ______________________ DOB: __/__/____ Sex: ____

Address: ___________________ City: ________________ State: ______ ZIP Code: __________

Phone (H): _______________ Phone (C): _______________ E-mail: _____________________

Emergency Contact: _________________ Phone: ______________ Relationship: ___________

Are you new to the practice? No Yes (how did you hear about us?): _________________

HEALTH HISTORY

Have you received a massage before? No Yes (how often?) ________________________

Do you engage in physical activity? No Yes (please describe): ___________________

Any medical conditions/surgeries? No Yes (please describe): ___________________

Are you currently taking medication? No Yes (please list): ________________________

Do you have any allergies/sensitivities? No Yes (please describe): ___________________

Are you pregnant or breastfeeding? No Yes (due date): _________________________

Any injuries in the past 72 hours? No Yes (please describe): ___________________

Do you bruise easily? No Yes

Primary reason(s) for visit today:

____

If applicable, how/when did this issue develop?

____

Have you received any prior treatment for this issue?

____

I affirm that I have stated all known medical conditions and answered all questions honestly. I agree to keep the massage therapist updated with any changes to my health status.

Appointment Cancellation Policy: If The Art of Health, LLC does not receive notice of an appointment change or cancellation twenty-four hours prior to scheduled appointment, I understand I will be charged a fee of 50% of the scheduled service price.

______________________________ ______________________________ ________________

Signature Printed Name Date