

# MORE MOBILITY MASSAGE

## Client Information

The following information is up-to-date on the date of \_\_\_\_\_

For (print client's name) \_\_\_\_\_

Please indicate by encircling or highlighting the best way to contact you after you have filled out the following:

Phone # 1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

Fax # \_\_\_\_\_ Other (pager, etc) \_\_\_\_\_

E-mail address \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of birth (mm/dd/yyyy) \_\_\_\_\_ Gender \_\_\_\_\_

Current and Previous occupation(s): \_\_\_\_\_

List currently taken medications/or medical treatments, also indicating quantity and

frequency of dosage \_\_\_\_\_

Physical and non-physical activities currently engaging in regularly (or have engaged in previously) that could possibly be affecting your current health status positively or negatively, indicating the frequency and duration/OR period of time in which you engaged in them if you no longer are involved in the activity)

\_\_\_\_\_

List any allergies or sensitivity to certain substances, scents or environments that the therapist should know about (This may effect the usage of certain oils/lotions)

\_\_\_\_\_

Areas you wish to not be touched? \_\_\_\_\_

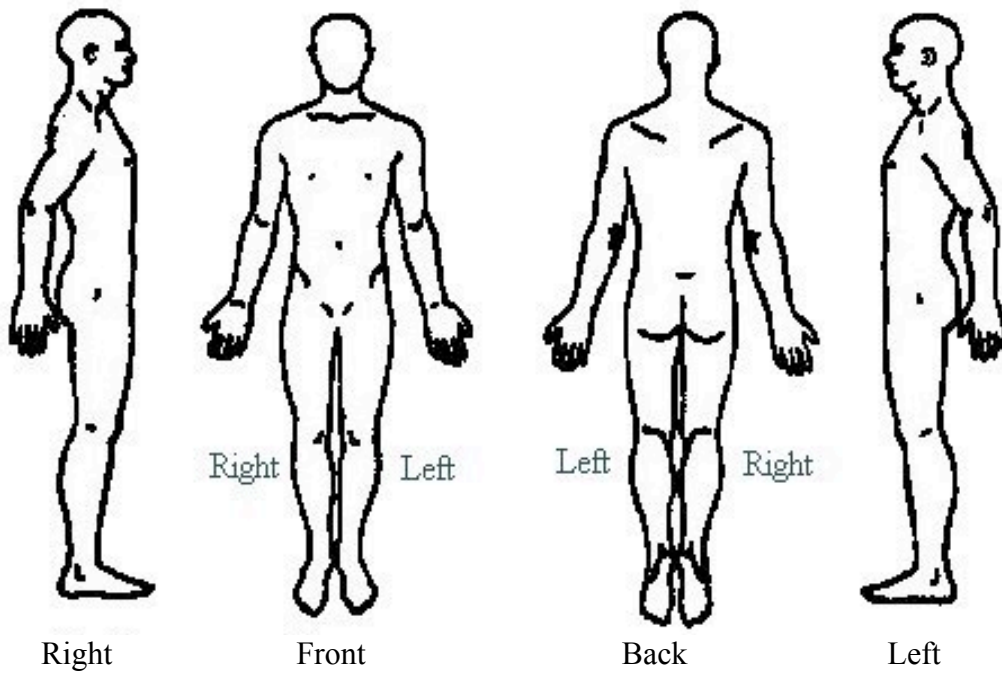
<intake information form continued on back of paper>

List any recent or past major surgeries, illnesses or physical disabilities or conditions such as cancer, heart attacks, pregnancy, broken or weak bones/joints, pinched nerves, open wounds, etc., indicating how long ago the injury occurred.

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Indicate areas that are in pain or are in need of attention:



I, (print name) \_\_\_\_\_ promise the information filled in this form has been filled to the best of my knowledge.

Signed \_\_\_\_\_ date \_\_\_\_\_