WARRIOR MASSAGE

New Client Intake Form

Today's Date _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ ZIP _____

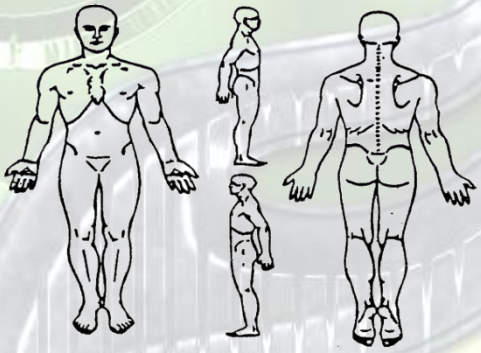
Phone (home/cell) _____ email _____

☐Yes, email me with updates, news, and offers from Warrior Massage. I understand my contact info will NEVER be released to any third party except with my express written permission.

Occupation: _____ Referred by: _____

Emergency contact name & number _____

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below _____



Describe any *chronic/recurring* pain not listed above: _____

What, if any, movements or activities aggravate or are affected by your condition? _____

Are you currently under the care of a physician, chiropractor, or receiving any other body therapies? If yes, what are you being treated for?

Please list any medications you are currently taking:

If yes, what for? _____

What specific areas would you like to focus on? _____

Are there areas you would NOT like massaged?_____

Please check any of the following that apply to you in the past or present::

Condition/Complaint	Past	Present	Condition/Complaint	Past	Present
Frequent Headaches Type:			**Pins/Needles in limbs, Hands or feet**		
Asthma			**Neurological problems**		
Cold Hands/feet			**Spinal Problems**		
Swollen ankles			**Herniated/Bulging Discs**		
Sinus Conditions			**Degenerative Joint Disease**		
Frequent Colds			**Rheumatoid Arthritis**		
Allergies (specify below)			**Sleep Disturbance**		
Loss of smell/taste			**Loss of Consciousness**		
Skin Conditions			**Whiplash**		
Painful/Swollen Joints			**Bruise Easily**		
Auto-immune disorder			**Sciatica**		
Cancer			**Epilepsy or Seizures**		
Varicose Veins			**Fainting Spells**		
Blood Clots/DVT			**Joint Replacement**		
Heart Problems			**Prosthetic or Missing limbs**		
Pacemaker			**Recent Surgery or Injury**		
High/Low BP			**Medical Device Implant**		
Diabetes					

*Further explanation of any condition or other information:*_____
_____
_____

- I understand the treatment here is not a replacement for medical care and/or diagnosis and it is recommended that I see a qualified physician for any conditions that I may have. I understand that the therapist/practitioner will not diagnose my condition, nor prescribe any treatment/pharmaceutical/etc.
- I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health. I hereby release Warrior Massage and its personnel from any liability arising from my failure to disclose any condition or sensitivity, or my failure to advise my therapist of any discomfort experienced during the session. I understand that at any time the therapist may determine that it is unsafe for massage to continue and require that I obtain a physician's medical release prior to treatment.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise I will be required to pay a cancellation fee PLEASE INITIAL _____**

Client signature_____Date_____