Welcome To… Greenfield Massage

Please fill out this client centered intake as completely as you can, we appreciate your honesty

Name: ____ Date: _______________

Address: ____

Phone: __________________________________ Email: ________________________________

D.O.B.: ________________________ Occupation: _____________________________________

Where did you hear about Greenfield Massage? ____

Have you ever had a professional massage? Y N if so, how often? ______________________

On average what is your preferred style of Massage? Circle all that apply.

Therapeutic Relaxing Deep Soft Other: ____

In your past sessions, is there anything that you especially liked or disliked? _________________

____

Are there any areas you prefer not to be massaged such as feet or face? ______________________

What is your main goal for the session today? ____

Do you have any pre-existing or chronic conditions?_____________________________________

____

Has there been a medical diagnosis Y N if so by whom? ____________________________

Is this condition getting progressively worse? Y N

What do you do to get relief/ Stress relief activities? _____________________________________

____

____

What activities aggravate your condition? ____

Are you currently under any other medical or therapeutic treatment? Y N

If yes, please explain: ____

____

May we contact your doctor if we feel a need? Y N

Primary Care Provider: ____

Are you experiencing any of these skin pathologies now?

Eczema	Psoriasis	Acne	Tinea (any type)
Rosacea	Poison Ivy	Athletes Foot	Warts
Boils	Staphylococcus		

Other/Explain____

I have completed this form to the best of my knowledge and have no contagious skin ailments that could be passed through skin to skin contact, that which has not been noted on this form.

____ ________________
Client Signature Date

Thank You