Karen Groneberg
LMT/Reflexologist

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MASSAGE THERAPY

Client Intake Form

Name: _____ Date: _____

Date Of Birth: _____ ☐ Female ☐ Male ☐ NB

Address: _____

Phone No.: _____ Email: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone No.: _____

Would you like to join our E-mail list for special offers? We don't spam. ☐ Yes ☐ No

MEDICAL HISTORY

☐ Acne
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorders
☐ Blood Disorders
☐ Cancer
☐ Cardiovascular Diseases
☐ Diabetes
☐ Depression
☐ Epilepsy/Seizure
☐ Fatigue
☐ Fungal Condition
☐ Gastrointestinal Disorders
☐ Headache/Migraine
☐ Herpes
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Hormonal Imbalances
☐ Hyper Pigmentation
☐ Hypo Pigmentation
☐ Hysterectomy
☐ Keloid Scarring
Other:
☐ Liver Condition
☐ Loss of Sensation
☐ Low Blood Pressure
☐ Lupus
☐ Organ Failure
☐ Metal Bone Pin/Plates
☐ Pregnancy
☐ Seborrhoea
☐ Transplant
☐ Thyroid Condition
☐ Warts

HEALTH INFORMATION

Did you undergo any recent surgery? ☐ Yes / ☐ No

Do you have any allergies to oils, essence or lotions? ☐ Yes / ☐ No

Are you pregnant or trying to get pregnant? ☐ Yes / ☐ No

How's your life style? ☐ Active/ ☐ Sedentary

List any prescription medication (dosage and frequency) you are now taking?

_____