

Headaches/Migraines Arthritis Hepatitis Ringing in Ears Osteoporosis HIV/AIDS Vertigo/Dizziness Bursitis Lyme Disease Vision Problems Tendonitis Currently Pregnant Hearing Loss Pins/plates/wires/artificial joint Currently Pregnant Vision Loss TMJ Currently Pregnant Scoliosis Given Birth Respiratory Asthma Cardiovascular Other Conditions Shortness of Breath High Blood Pressure Diabetes Smoker Low Blood Pressure Diabetes Other Heart Attack Digestive Conditions Stroke Other Stroke Other Sciatica Pacemaker Other —	8 . 20 a	Client Intake Form	
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- $ -$		Varicose Veins	
		Blood Clots	
	Location:		
☐ Multiple Sclerosis	Multiple Sclerosis		
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Please list & date any major surgeries or accidents:

Please list any medications, including aspirin, herbs & supplements:

Are you allergic to any food, nuts, fragrances, or other?

Have you been seen by a massage therapist before? When?

I confirm that the information provided is true and accurate. Massage therapists are not liable for any withheld information. I am aware of the benefits and risks of massage therapy. I acknowledge massage therapy is not a substitute for medical care, medical examination, or diagnosis. I give my consent to receive massage therapy.