Multicolor Massage Therapy, LLC
Juan Rodriguez, LMT | Licensed Massage Therapist | Lic.#: MT012317
485 Huntington Road #196, Athens, GA 30606 | (404) 954-0904 | multicolorwellness.com

Client Intake Form

Personal Information

First Name: _____ Last Name(s): _____

Preferred Name(s): _____ Date of Birth: _____ Age: _____

Gender: _____ Occupation: _____

Street Address:_____

City, State, Zip Code: _____

Phone #: _____ Email Address: _____

How did you hear about us? Who referred you? _____

Emergency Contact Person: _____

Relationship to you: _____ Emergency Contact Phone: _____

Massage Experience

Have you had a professional massage before? ☐ Yes ☐No

- If yes, what types of massage have you had? ☐Swedish ☐ Deep tissue ☐Other: _____

How long have you been receiving massage therapy? _____ Frequency of massages?_____

What are your goals for treatment? _____

_____

Current Health

Do you exercise regularly and/or participate in any sports? ☐ Yes ☐No

- If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? ☐ Yes ☐No

- If yes, describe: _____

Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐No

- If yes, describe: _____

Do you experience stress in your work, family, or other aspect of your life? ☐ Yes ☐No

- If yes, describe: _____

Are you experiencing tension, stiffness, discomfort or pain? ☐ Yes ☐No

- If yes, describe: _____

Have you recently had an injury, surgery, or areas of inflammation? ☐ Yes ☐No

- If yes, describe: _____

Do you have sensitive skin? ☐ Yes ☐No

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

- If yes, please explain: _____

List any known allergies: _____

Have you recently had a tattoo or piercing? ☐ Yes ☐No If yes, please explain: _____

List any medications you are currently taking: _____

Health History

Musculoskeletal
☐Bone or joint disease
☐Tendonitis/Bursitis
☐Arthritis/Gout
☐Jaw Pain (TMJ)
☐Lupus
☐Spinal Problems
☐Migraines/Headaches
☐Osteoporosis

Circulatory
☐Heart Condition
☐Phlebitis/Varicose Veins
☐Blood Clots
☐High/Low Blood Pressure
☐Lymphedema
☐Thrombosis/Embolism

Respiratory
☐Breathing Difficulty/Asthma
☐Emphysema
☐Allergies, specify:
☐Sinus Problems

Nervous System
☐Shingles
☐Numbness/Tingling
☐Pinched Nerve
☐Chronic Pain
☐Paralysis
☐Multiple Sclerosis
☐Parkinson's Disease

Psychological
☐Anxiety/Stress Syndrome
☐Depression

Skin
☐Allergies, specify:
☐Rashes
☐Cosmetic Surgery
☐Athlete's Foot
☐Herpes/Cold Sores

Digestive
☐Irritable Bowel Syndrome
☐Bladder/Kidney Ailment
☐Colitis
☐Crohn's Disease
☐Ulcers

Reproductive
☐Pregnant, stage: _____
☐Ovarian/Menstrual Problems
☐Prostate

Other
☐Cancer/Tumors
☐Diabetes
☐Drug/Alcohol/Tobacco Use
☐Contact Lenses
☐Dentures
☐Hearing Aids

Any other medical condition(s) not listed:
_____
_____
_____

Please explain any of the conditions that you have marked above:
_____
_____
_____

Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I am responsible for all charges for all service provided at the time of service. I understand that my fee for service today is: _____.

_____ _____
Signature Date

_____
Signature of parent or legal guardian (if client if a minor)