Multicolor Massage Therapy, LLC
Juan Rodriguez, LMT | Licensed Massage Therapist | Lic.#: MT135507 (Texas), MT012317 (Georgia)
(404) 954-0904 | multicolorwellness.com

Client Intake Form

Personal Information

First Name: _____ Last Name(s): _____

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

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

What are your goals for treatment? ☐Relaxation ☐Pain Management ☐Other:_____

Current Health

Do you exercise regularly and/or participate in any sports? What kind of exercise/sports?	☐ Yes ☐No
Do you perform any repetitive movement in your work, sports or hobby? Describe:	☐ Yes ☐No
Do you sit for long hours at a workstation, computer, or driving? Describe:	☐ Yes ☐No
Do you experience stress in your work, family, or other aspect of your life?	☐ Yes ☐No
Are you experiencing tension, stiffness, discomfort, or pain? Describe:	☐ Yes ☐No
Have you recently had an injury, surgery, or areas of inflammation? Describe:	☐ Yes ☐No
Do you have sensitive skin? Explain:	☐ Yes ☐No
Do you have any allergies to oils, lotions, or ointments? Explain:	☐ Yes ☐No
Have you recently had a tattoo or piercing? Explain:	☐ Yes ☐No

List any medications you are currently taking: _____

Health History

Please indicate if you have any problems in any of the following areas:

Muscles and Bones	☐ Yes ☐No	Explain:
Skin	☐ Yes ☐No	Explain:
Circulatory	☐ Yes ☐No	Explain:
Respiratory	☐ Yes ☐No	Explain:
Nervous System	☐ Yes ☐No	Explain:
Psychological	☐ Yes ☐No	Explain:
Are you pregnant?	☐ Yes ☐No	Explain:
Other	☐ Yes ☐No	Explain:

Client Agreement and Cancelation Policy

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 or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, 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 I will be charged for the full cost of the service if I do not cancel my appointment 24 hour in advance or if I do not show up to my appointment.

_____ _____

Signature Date

_____

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