Pure Serenity Massage LLC

Date_____

*Name*_____

*Email:*_____ ***Would you like to receive emails from us about our openings and promotions?*** *Circle: Yes or No*

Address_____City_____Zip_____

CIRCLE number you would like us to use first for confirmation calls:

Home#_____Cell#_____ Work:_____

DOB

_____Employer_____Occupation_____

Emergency Contact Name_____ Phone Number_____

CLIENT INTAKE FORM

Have you ever received a professional massage? Y___N___

If yes how long has it been?

Are you on any medications (vitamins, herbs or pharmaceuticals)? Please List.

Describe any surgeries, accidents or injuries you have had in the last 5 years.

Do you have any ongoing, chronic pain or discomfort? Where?

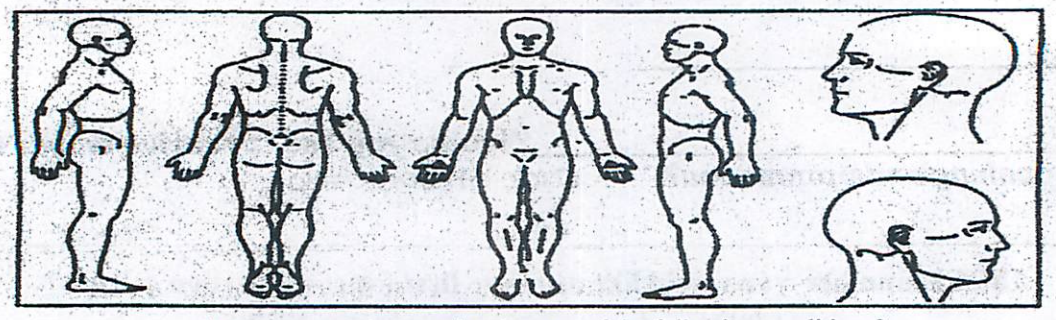
Are you receiving any other type of medical treatment that I need to be aware of? Y___N___

Are you allergic to any seafood, peanuts, oils, lotions, herbs, and essential oils? Y__N__
If yes please list:

HIPPA Notice of Privacy Practices: Attached to this clipboard is our notice of privacy practices please read it over and sign and date this page acknowledging that you have reviewed and understand the practices.

Clients Signature:_____**Date**_____

PLEASE SHADE IN WHERE YOU EXPERIENCE PAIN ON THE DRAWING BELOW



Are you currently experiencing any of the following conditions?
__Flu, Cold __Inflammation ___Fever ___Infection

Please check any of the following conditions that currently affect you

Musculoskeletal	**Circulatory**	**Digestive**
_Fibromyalgia	_Anemia	_Ulcers
_Spasms/Cramps	_High Blood Pressure	_Hepatitis
_Sprains/Strains	_Low Blood Pressure	_Gas/Bloating
_Osteoporosis	_Varicose Veins	
_Arthritis	_Heart Condition	
_TMJ	_Blood Clots/Phlebitis	**Other**
_Tendinitis	_Diabetes	_Ear Infection
_Whiplash	**Skin**	_Vertigo
_Carpal Tunnel Syndrome	_Fungal Infection	_Insomnia
_Sciatica	_Impetigo	_Anxiety/ Panic Attacks
_Thoracic Outlet Syndrome	_Dermatitis/Eczema	_PMS
_Other	_Psoriasis	_Grief Process
	_Open Wound or sores	_Cancer
Respiratory	_Rashes	_Substance Abuse
_Sinusitis	_Athletes Foot	_Pregnancy
_Asthma	**Nervous System**	_Chronic Fatigue
_Trouble Breathing	_Multiple Sclerosis	_Lupus
_Dizziness	_Parkinson's Disease	_Kidney Disease
_Other	_Neuritis	_Edema
	_Spinal Cord Injury	_Depression
		_Diabetes
	_Stroke	_Other
	_Seizure Disorders	
	_Numbness/Tingling	

The above information is accurate and true to the best of my knowledge. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health.

Signature_____**Date**_____