Rejuvenation Massage Confidential Client Intake Form

Name ______________________________ Date ______________

Street ____________________________ City ____________ Zip ____________

Phone #'s: (H) ______________ (W) ______________ (C) ______________

Email ______________________________ Is this a good way to reach you? Y / N

Occupation ______________________ Date of Birth ______________________

Emergency Contact ______________________ Phone # ______________

MD/Physican ______________________ Phone # ______________

Whom may I thank for this referral? ______________________________

Massage History and Treatment Information

What is the main reason for this visit? ______________________________

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Have you had a professional massage before? Y / N If so, how often?__________

Please list any medications you are currently taking ______________________

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Are you currently receiving treatment from a medical practitioner, chiropractor, or physical therapist? If yes, please explain ______________________________

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TMJ History (if applicable)

What symptoms do you currently have? ______________________________

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How long have they been a problem? ______________________________

What helps it? ____

What makes it worse? ____

Do you have difficulty or pain when opening your mouth or chewing? Y / N

Do you have popping, clicking or a grating noise when opening or closing? Y / N

Do you have ringing or stuffiness in your ears? Y / N

Do you have headaches? Y / N How often? ______________ Where? ______________

Have you had any history of trauma to your face, head, neck or jaw? Y / N . If Yes, please explain ____

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Have you seen anyone about this condition? Y / N . If Yes, who and what did they do?

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