LAVENDER ROSE
SENIOR MASSAGE, LLC

# *Client Intake Form*

**Personal Information**

Name _____ Date _____

Phone Number _____ Male ☐ Female ☐

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

Goal for massage session _____

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

Date of last massage

List any hospitalizations, injuries, accidents, or surgeries in the past year

_____

_____

Are you currently taking any blood thinning medications? Yes ☐ No ☐

Please circle any condition that applies to you:

| | |
|---|---|
| Heart Disease | Diabetes |
| Blood Clots | Stroke |
| Arthritis | Decreased Sensation |
| Cancer | Epilepsy/Seizures |
| Lung Disease | Low/High Blood Pressure |

I understand that the massage I receive is provided for the basic purposes of relaxation, improved circulation and relief of muscular tension. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness. I affirm I have stated all my medical conditions. I understand that the Licensed Massage Therapist reserves the right to refuse to perform massage if she deems the client to have a condition for which massage is contraindicated.

Signed _____ Dated _____

CONFIDENTIAL