
Beau P. Laurence Massage Therapy

confidential \triangle New Client Intake Form \triangle confidential

Today's Date _____ Date of Birth _____

Name (legal) _____ (preferred) _____

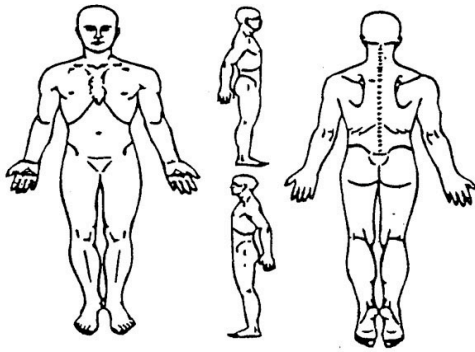
Preferred Pronoun _____ Occupation _____

Full Address _____

Phone _____ email _____

Emergency contact name & number _____

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below _____



Describe any chronic pain/tension _____

What makes it better -or- worse? _____

Are you currently under the care of a physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? _____

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking (incl. HRT): _____

Describe any surgeries (incl. dates): _____

Are you pregnant or think that you might be pregnant? _____

What specific areas would you like for me to stay away from? _____

Anything you would like worked on? _____



△ Intake Form – Page 2 of 2 △

What do you hope to accomplish with this massage? (i.e. relaxation, decrease back pain, increase flexibility, etc.) _____

How frequently and for how long do you exercise and what do you do? Include sports, biking, yoga, gardening and/or other physical activities: _____

Please check any of the following that apply to you in the past or present::

Condition/Complaint	Past	Present	Condition/Complaint	Past	Present
Headaches <i>Type:</i>			Pins and Needles in arms, legs, Hands or feet		
Allergies (specify above)			Anxiety		
Frequent Colds			Arthritis		
High/Low BP			Artificial/Missing limbs		
Cancer			Bruise Easily		
Varicose Veins			Constipation/Diarrhea		
Blood Clots/DVT			Contact Lenses		
Heart Problems			Dentures/Partials		
Loss of smell/taste			Depression/Panic		
Pacemaker			Hemorrhoids		
Swollen ankles			Herniated/Bulging Discs		
Fainting Spells			HRT (testosterone, estrogen, other)		
Painful/Swollen Joints			Loss of Memory		
Diabetes			Muscular Tension		
Asthma			Neurological problems		
Sinus Conditions			Osteoarthritis		
Epilepsy or Seizures			Sciatica		
Skin Conditions			Sleep Disturbance		
Cold Hands/feet			Spinal Problems		
Auto-immune disorder			Whiplash		

Further explanation of any condition or other information: _____

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

- ☐ Need to move or change positions ☐ Sighing, yawning, change in breath ☐ Stomach gurgling
☐ Emotional feelings and/or expressions ☐ Movement of intestinal gas
☐ Energy shifts ☐ Falling asleep ☐ Memories

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I agree to give at least 24 hours notice of cancellation of appointment, otherwise will be expected to pay for session PLEASE INITIAL _____

Client Signature _____ Date _____