1028 Ninth Street, Green Bay, WI 54304
Phone: (920) 490-9699
email@9thstwellness.com
www.9thstwellness.com **(Please Print)**

Client Intake Form

Name _____ **DOB** _____

Phone _____ **Email** _____

Address_____

City _____ **State** _____ **Zip Code** _____

Emergency Contact_____ **Phone** _____

Referred by_____Reason for initial visit _____

Have you had a massage before? Yes No Injuries or Surgeries in the past? Yes No

Please describe _____

Allergies _____

Medications _____

Pregnant Yes No How far along? _____

_____ Arthritis	_____ Autoimmune	_____Bruise easily	_____ Cancer
_____ Car Accident	_____Carpal Tunnel	_____Depression	_____ Diabetes
_____ Disc Problems	_____Epilepsy	_____Headaches/Migraines	_____ Heart condition
_____ High/Lo Blood Pressure	_____Numbness/Tingling	_____Old injuries	_____ Plantar Fasciitis
_____ Plantar Warts	_____ Rotator cuff injury	_____Sciatica	_____ Scoliosis
_____ Sinus Problems	_____TMJ	_____ Varicose Veins	_____Skin conditions

Comments_____

Areas you would **NOT** like worked on: _____ Back _____Neck _____ Shoulders _____Hips _____Buttocks_____Face

_____ Feet _____Arms _____Hands _____Scalp _____Abdomen _____Other

The above information is accurate to the best of my knowledge, and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain or discomfort during the session. I understand this does not deter me from seeking medical treatment for medical conditions. I understand that no inappropriate comments or conduct will be tolerated. Any indications of such behavior will automatically end the session.

I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part if I forget to do so. I agree to hold harmless the establishment, its employees, and the therapist from and against any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims are groundless, false and fraudulent.

Signature_____ Date _____

Therapist Signature_____ Date_____