506 N. Union Street
Wilmington DE 19805
(302) 887-9411
www.telo-massage.com

Client Intake Form

Personal Information

Name_____ DOB: _____-_____-_____ Date: _____/_____/_____

Address: _____ City_____ State____ Zip_____ Email_____

Phone Number ( )_____-_____ Emergency Contact_____ Number ( )_____-_____

Would you like to be emailed upcoming specials and coupons? ☐ Yes ☐ No

How did you hear about us? ☐Internet ☐Ad ☐Referred by: _____ ☐ Other:_____

Current Occupation?_____ Hours a day sitting? _____ Hours a day standing? _____

Hours a day at a computer?_____ Do you lift heavy equipment? ☐ Yes ☐ No If yes, how many lbs.?_____

Health Information

Reason for visit: _____ Have you had a massage before? ☐Yes ☐ No

If yes please explain the type of massage: _____

Have you had any injuries in the past 72 hours? ☐Yes ☐No If yes, please explain:_____

Please list Serious Illnesses, Injuries, or Surgeries in the past 24 months?_____

Do you have any allergies? ☐Yes ☐ No If yes, please list_____

Are you on any medications? ☐Yes ☐ No If yes, please list_____

Please check all that apply:

Bruise Easily	☐ yes ☐ no	Contact lenses	☐ yes ☐ no
Carpal Tunnel	☐ yes ☐ no	Diabetes	☐ yes ☐ no
Pregnant	☐ yes ☐ no	Stress	☐ yes ☐ no
Epilepsy	☐ yes ☐ no	TMJ (jaw pain)	☐ yes ☐ no
Cancer	☐ yes ☐ no	Headaches	☐ yes ☐ no
Sciatica Pain	☐ yes ☐ no	Chiropractic	☐ yes ☐ no

Are there any areas on your body that you would **NOT** like massaged? ☐ YES ☐ NO

If yes please list: _____

What type of pressure do you prefer? ☐ Light ☐ Medium ☐ Hard

Informed Consent: Please take a moment to carefully read the following information and sign where indicated.
The above information is completely accurate to the best of my knowledge and I am freely giving my permission to be massaged. I have been made aware that massage is a contraindication for some serious medical conditions, and it may be necessary to obtain a doctor's release or prescription before beginning therapy. I agree to update the massage therapist in regard to any changes in my health and understand that there shall be no liability to the therapist's part if I forget to do so. Should I have to cancel an appointment for any reason, I agree to give the therapist a 24-hour notice. I have also been made aware that any inappropriate behavior will automatically terminate my massage session with no return of funds.

Patient Signature: _____ Date: _____