Grand Rapids Natural Health, LLC

www.grnaturalhealth.com

638 Fulton St. W Suite B
Grand Rapids, MI 49504

T (616) 264-6556
F (616) 432-3564

Massage Therapy & CranioSacral Therapy

client intake form

Personal Information

Name_____Phone _____

Address_____City, State, Zip _____

Email_____Date of Birth _____

Emergency Contact_____Phone _____

Massage Information

How did you hear about us?

_____

Have you ever had a professional massage before?

☐ yes ☐ no

If yes, how often do you receive massage therapy?

_____

If yes, do you have a style or pressure preference?

☐ yes ☐ no

Specify : ☐ light pressure ☐ medium pressure

☐ deep pressure ☐ Other _____

What Type of massage are you seeking today?

☐ Relaxation ☐ Deep Tissue/ Therapeutic

☐ Sports ☐ Pregnancy ☐ Raindrop therapy

☐ Other_____

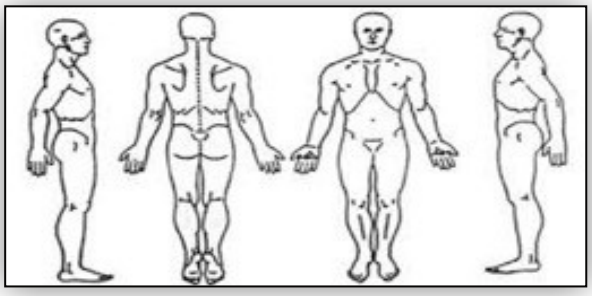
Do you exercise regularly? ☐ yes ☐ no

What are your common areas of pain or tension?

_____

_____

Circle any areas you would like the Massage Therapist to concentrate on during the session:



Medical History

Do you suffer from chronic or persistent pain/ discomfort?

_____

If so, for how long? _____

Do you know cause of pain?

_____

Do you see a chiropractor? ☐ yes ☐ no

If so, how often?

_____

Are you currently under medical care? ☐ yes ☐ no

Are you currently taking any blood pressure medication?

_____

_____

Please indicate any conditions that you have had or currently have:

☐ headaches, migraines	☐ varicose veins
☐ arthritis, tendonitis	☐ cancer, tumors
☐ cancer, tumors	☐ pregnancy___weeks
☐ blood clots	☐ TMJ problems
☐ neck / back injury	☐ skin condition
☐ high / low blood pressure	☐ joint replacement / surgery

Explain any condition you have marked above:

_____