



Kari E. Hoyt  
 LMT NCTMB  
 Therapeutic Massage  
 Client Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone-C:(\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_ Phone-H:(\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_ DOB: \_\_\_\_\_

E-mail: \_\_\_\_\_ How were you referred/by whom? \_\_\_\_\_

Have you experienced massage before? \_\_\_\_\_

If yes, what is your history with massage? \_\_\_\_\_

What brings you here today? \_\_\_\_\_

What are your goals for this session? \_\_\_\_\_

Please list daily physical activities involved in your job and life: \_\_\_\_\_

Please list any major traumas that you have ever had and their approximate dates (car accidents, broken bones, surgeries, etc.): \_\_\_\_\_

Please circle any of the following conditions if they have affected you in the last 2 years:

- |                    |                            |                                 |
|--------------------|----------------------------|---------------------------------|
| Diabetes           | Varicose Veins/Blood Clots | Other Circulatory Problems      |
| Cancer             | High/Low Blood Pressure    | Headaches/Migraines             |
| Glasses/Contacts   | Pregnant (or trying)       | Infectious Disease/HIV/AIDS     |
| Sleep Difficulties | Osteoporosis               | Irregular Digestion/Elimination |
| Allergies          | Rash/Athlete's Foot/Warts  | Arthritis/Tendonitis            |

Are you currently under medical supervision? Y/N Physician: \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_

Please take a moment to check-in with your body and notice if there is anything else that you would like kept in mind for this session: \_\_\_\_\_

Places not to miss? \_\_\_\_\_ To avoid? \_\_\_\_\_

I understand that the services offered are not a substitute for medical care and give my consent to receive treatment. Any information provided is for educational purposes only and not diagnostic or prescriptive in nature. I also give my permission for the LMT with whom I work to discuss information pertinent to the treatment of my condition with my health care team should she deem it necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (if under 18): \_\_\_\_\_ Date: \_\_\_\_\_

The following are **normal** relaxation reactions that sometimes occur during massage:

- movement or release of intestinal gas  laughing/crying  strong emotions
- cognitive or felt memories  energy shifts  stomach gurgling  need to move or change position  drop in body temperature/need for more covers  twitching

Emotions are welcome here. Please trust your body to express what it needs to, and let me know if there is anything that I do to help you feel more comfortable at any time during our session.