

Karen April

CLIENT INTAKE FORM

Name _____ Email: _____ DOB _____

Address _____ How did you hear about us? _____

Phone _____ Emergency Contact _____ Phone _____

****Please answer the questions below.**

What type of treatment/service are you seeking today? Massage Energy Yoga Consultation

Have you experienced any of the following services before? Massage Energy Yoga None

Are you on any medication? Yes No If yes, please list and explain _____

Are you pregnant? Yes No _____

Do you have any allergies/sensitivities? Yes No If yes, please list _____

****Please mark any of the following conditions you may currently have.**

Joint Replacements

Cancer

Neuropathy

Headache/Migraine

Diabetes (Type: _____)

High /Low Blood pressure

Fibromyalgia

Arthritis

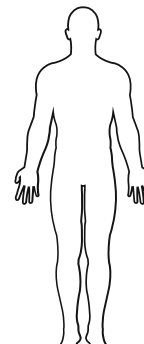
Depression

Anxiety

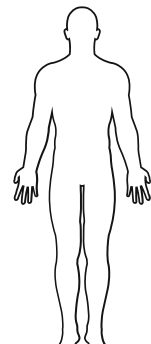
Others, please specify:

Goals for this session:

Circle any areas of discomfort



Front



Back

I understand that this work is for the purpose of stress reduction, relief from muscular tension, and/or for increasing circulation. I understand that Karen April LMT, LLC does not diagnose illness, disease, nor any physical or mental disorder. Karen April LMT, LLC does not prescribe medical treatment nor perform spinal manipulations. I have informed Karen April LMT, LLC of all of my current medical conditions (physical and mental) at this time.

Signature _____

Date _____