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Massage & Reiki Client Intake Form

Please fill out to the best of your ability, sign, date and bring with you to your first appointment.

APPOINTMENT DATE / /

Name _____ Birth date / / Age _____

Address _____
Street City State Zip

Phone: Home () Work () Mobile ()

Occupation _____ E-mail _____

Where did you find out about Grace? _____

Have you had massage therapy before? Yes No If yes, when? _____

Any general complaints? Yes No If yes, describe _____

Do you have any physical injuries? Yes No If yes, describe _____

Do you have any form of heart disease? Yes No

Do you have hypertension? Yes No

Do you have high blood pressure? Yes No Low blood pressure? Yes No

Please describe any surgery you have had? _____

Please list all medications: _____

What symptoms would you like to improve? _____

How do you feel today? _____

Please describe your diet:

Is this your typical diet? Yes No

Do you take any dietary supplements or herbs? Yes No If yes, please describe: _____

Do you desire nutritional and herbal guidance or support? Yes No

What are the stresses in your life? _____

What activities help you with stress reduction? _____

How often do you do these activities? _____

Do you exercise regularly? Yes No If yes, how? _____

Signature of Client

Date of Signature

Signature of Massage Therapist

Date of Signature

We appreciate your patience and honesty in filling out this form