Kenny Lyons LMT • *Confidential Client Intake Information*

(*Please print clearly*)

Name: _____ M/F: ___

Reason for Appointment: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (H)_____ (W)_____ (C)_____

Occupation: _____ Date of Birth: _____

Emergency Contact Person: _____ Phone #: _____

How were you referred or whom can we thank? _____

E-mail address: _____

(E-mail address is for the sole use of Kenny lyons LMT. It will not be shared with any third parties)

Have you had a professional massage before? ___**Yes** ___**No**

Female clients only. Are you pregnant or do you think you might be pregnant? ___**Yes** ___**No**

Have you ever tested positive for Covid-19:___**Yes** ___**No** **If yes, when**_____

Have you received the Covid-19 vaccine?:___**Yes** ___**No** **If yes, when**_____

Medical History. Please check if applicable:

___ **Headache/Migraine**	___ **High Blood Pressure**	___ **Diabetes**	___ **Peripheral Neuritis**
___ Stiff Neck	___ Low Blood Pressure	___ Bruises	___ Epilepsy
___ **Low Back Pain**	___ **Poor Circulation**	___ **Blood Clot**	___ **Asthma**
___ Neck Pain	___ Anemia	___ Fatigue	___ Osteoporosis/osteomalacia
___ **Sciatica**	___ **Stroke/Heart Attack**	___ **Cancer**	___ **Lupus**
___ Leg/Foot Pain	___ Spinal Problems	___ Swollen Joints	___ Edema
___ **Arm/Hand Pain**	___ **Varicose/Spider Veins**	___ **Allergies**	___ **Chronic Constipation**
___ Broken Bones	___ Skin Problems	___ Fever	___ Arthritis
___ **Numbness/Tingling**	___ **Fibromyalgia**	___ **Multiple Sclerosis**	___ **Dentures**

Any Injury/Trauma/Auto (date/brief description): _____

_____

Please list your Primary Care Physician (optional):

Name _____ Phone# _____

If any contraindications are present, may I consult with your physician? ___**Yes** ___**No**

Please list all surgeries: _____

Please list all medications currently being taken and conditions being treated: _____

_____ (use back if needed)

I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation.

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. It has been made very clear to me that massage is not a substitute for medical exams and/or diagnosis and that is recommended that I see a physician for any physical problem that I might have.

Because the massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

There is no charge for appointments cancelled at least 24 hours before appointment time. You will be charged the full amount for failing to show up for a scheduled appointment.

I understand that my records are protected under federal and state regulations and cannot be disclosed without my express written consent.

Name: _____ Date: _____