New Client Intake
Kathryn Clippard LMT
LMT# 19681
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Portland, Oregon 97209
(503) 417-1774

Name: _____ Date of Birth: _____/_____/_____

Home Address (street, city, zip): _____

Phone: _____ Email: _____

Occupation: _____ Employer: _____

Health Insurance Co: _____ Provider phone #: _____

Group Number: _____ ID Number: _____

In Case of Emergency Contact:

Name & Relationship: _____ Phone: _____

How did you find us? _____

Is this your first professional massage? ▢ Yes ▢ No

Have you had any illnesses, surgeries, accidents, or injuries that may still be affecting you? If so, please provide dates and details of the incident(s):

_____

_____

Please indicate if you have or have had any of the following conditions:

▢ Joint problems	▢ Osteoporosis	▢ Cancer
▢ Back problems	▢ Diabetes	▢ MRSA
▢ Lymph Node problems	▢ Varicose veins	▢ Blood Clots
▢ High blood pressure	▢ Heart condition	▢ HIV or AIDS
▢ Kidney problems	▢ Hepatitis or liver issues	▢ Skin rash or disorder

▢ Allergies/sensitivities: _____ ▢ Irritable Bowel/Digestive Issues

▢ Chronic pain: if so, where? _____

Any other medical condition(s) not listed? _____

Please list any medications you are currently taking:_____

Do you have specific likes/dislikes regarding massage? _____

What is your primary goal for today's session? _____

_____