



Soully Inspired LLC

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Massage Client Intake Form

Date _____	
Name _____	Phone _____
Address _____	Email _____
City _____ State _____ Zip _____	Birth Date _____
Occupation _____	Referred By _____
Emergency Contact _____	Phone _____

Your General and Personal Information:

When was your most recent massage? _____

What was great or not so great about your last massage? _____

I receive how many of hours of sleep each night... _____

Please rate your stress level:

← 0 1 2 3 4 5 | 6 7 8 9 10 →

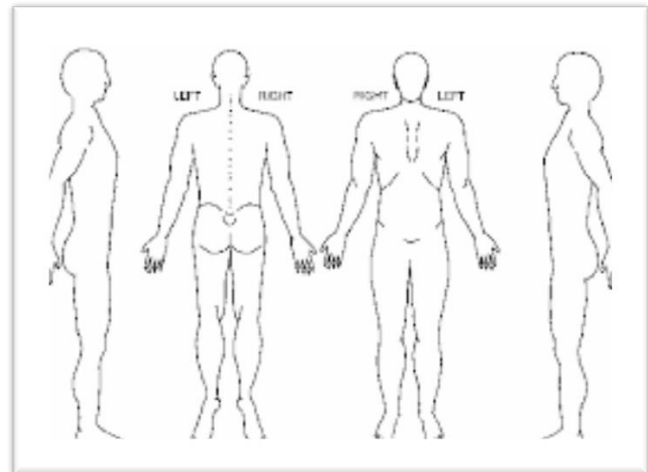
Cool as a Cucumber Ready to Crash

Please rate your pain level:

← 0 1 2 3 4 5 | 6 7 8 9 10 →

No Pain Excruciating

Please circle areas of pain or discomfort



Please circle any health issue that applies to you in the list below.

Frequent Headaches
Joint stiffness or swelling
Arthritis
Osteoporosis
Bursitis
Tendonitis
Scoliosis
TMJ or mouth pain
Back pain
Stabbing pain
Surgeries _____

Rashes
Acne
Athlete's foot or fungus
Open Wounds or cuts
Diabetes I or II
Heart Disease
Fibromyalgia
Multiple Sclerosis
Muscular Dystrophy
Epilepsy

Parkinson's Disease
Alzheimer's Disease
Recent Surgery
Edema (Swelling, water retention)
Lymphedema
High Blood Pressure Treated/Untreated
Asthma
Cancer
Pregnancy _____ Months
Other _____

Please elaborate on any of the list above or comment on your overall health and well being, thank you.
