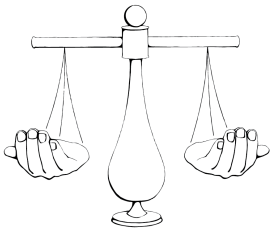


Michigan Clinical & Therapeutic Massage
2815 Michigan St., Suite B Grand Rapids, MI 49506
Phone: (616) 608-4094 Fax: (616) 608-4168
www.mi-ctm.com

Intake Form

Name:_____ Phone:(H)_____ (Cell)_____

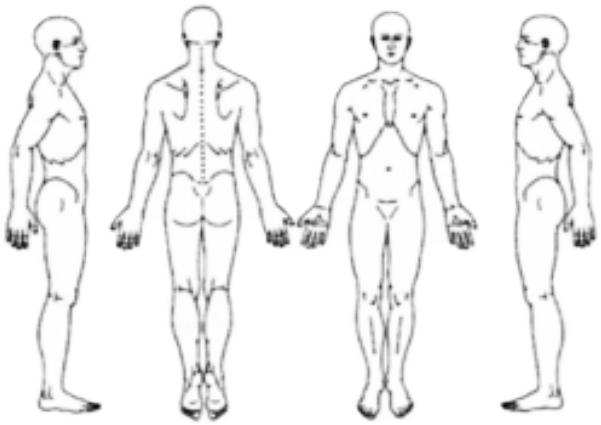
Street:_____ City:_____ State:_____ Zip: _____

Date of Birth: _____ Age: _____ Male / Female Marital Status: _____

Email Address: _____ How did you hear of us? __Facebook ___Instagram ____Twitter ____Referral
If referred, by whom?_____

What are you getting done today? Deep Tissue Massage □ Lymphatic Drainage □ Hot Stone □ Bamboo Fusion □
Cranial Sacral □ Sports □ Cupping □ A Shiatsu □ Facial □ Other(s) _____
Have you ever received Massage Therapy? NO / YES
If yes, what type of massage have you experienced? _____

Shade in any area(s) where you are feeling discomfort



Do you have the following today?
Sunburn Cuts, Burns, Bruises □
Inflammation Irritated Skin □
Severe Pain □ Poison Ivy □
Headache Cold or Flu □

What type of touch do you prefer?
Light/Meditative □
Heavy/Invigorating □
Deep/Trigger Point □

How many times a week do you participate in activities or sports?
Less than one hour □ Three to four hours □
One to two hours □ Five or more hours □

How much water do you drink per day?
□ Two to four glasses
□ Five to seven glasses
□ Eight or more glasses

What are your goals for massage? □ Relaxation □ Maintenance Massage □ Other_____

Are there any other health conditions I should be aware of? NO / YES If yes, please explain:
_____

What is your music preference? _____

Please read and initial the following, and sign below.

____ I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

____ I am responsible for paying $45 for any appointment cancellation of less than 24 hours.

Signature _____ Date _____