Pete Pfannerstill, Ph.D., L.M.T. MA # 24089

Client Intake Form

Name: _____ Email: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

I am primarily Right / Left handed Occupation: _____

Employer: _____ Bus. Phone: _____

Referred by: _____ (Optional:Age: _____ Birth date: _____)

Past and Present Health History - Check the following conditions that may apply to you:

□ Allergies	□ Dizziness	□ Pregnant
□ Anemia	□ Fatigue	□ Sciatica
□ Arthritis	□ Frequent headaches	□ Scoliosis
□ Blood clots	□ Heart Problems	□ Sinusitis
□ Broken Bones	□ High blood pressure	□ Skin disorders
□ Cancer	□ Joint Pain	□ Sleeplessness
□ Contact lenses	□ Kidney problems	□ Spinal problems
□ Depression	□ Low Back Pain	□ Surgery
□ Diabetes	□ Metal plates or screws	□ Varicose veins

□ Other: _____

□ Recent Injuries (2 yrs) or other medical conditions: _____

Have you had alcohol in the past 24 hours? □ Yes □ No Do you smoke? □ Yes □ No

Are you currently under the care of a physician □ Yes □ No Condition: _____

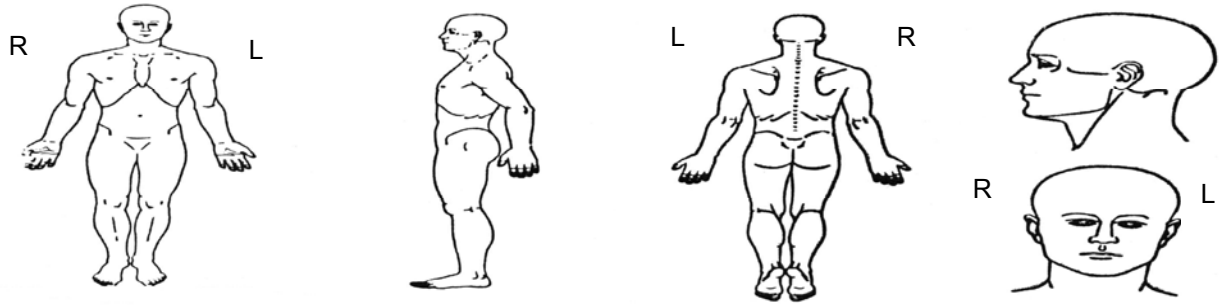
Medications you are taking: _____ For: _____

Have you received Chiropractic care? □ Yes □ No Frequency? _____ D.C. _____

Have you received a professional massage? □ Yes □ No -- Relaxation / Deep tissue / Other

Training for _____ Why are you seeking massage today?_____ _____

Please indicate any areas of pain or discomfort:



RELEASE: Massage therapy given by this LMT is intended for the relief of muscle tension or spasm, reduction of stress, and to assist venous and lymphatic circulation. It is my responsibility to provide pertinent health information and to inform the LMT of any changes. By signing this release, I hereby declare that I have provided this LMT with all relevant information necessary for the proper application of massage therapy and I expressly give my permission for this LMT to provide such therapy.

Signature: _____ Date: _____

Initial_____ I understand that I will be billed the full rate if I miss or cancel my appt. within 24 hours