



Sweet Earth Therapeutic Massage LLC

Myrna Lovell-Jones, LMT, CMT

1575 Old Alabama Road –Ste 105

Roswell, GA 30076

404-556-6363

Email: info@sweetearthmassage.com

www.sweetearthmassage.com



CLIENT INTAKE FORM

Full Name: _____ DOB: _____

Phone #: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Emergency Contact: _____ Phone #: _____

Relationship: _____

Physician: _____ Phone #: _____

Medical History:

Health Conditions: _____

Current Medications: _____

Please indicate any of the following conditions that you currently have by circling:

Headaches	Allergies	Arthritis	Tendonitis
Abnormal skin condition	Joint surgery	TMJ	Cancer
Heart/circulation problems	High / Low blood pressure	Diabetes	Major accident
Varicose veins	Blood Clots	Fibromyalgia	Neck / back injuries
Numbness	Sprains/Strains	Recent Injuries	Epilepsy or Seizures

Explain Any Conditions You Have Marked Above: _____

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CLIENT INTAKE FORM

Do you suffer from claustrophobia? Y N

Do you suffer from stress? Y N

Do you have a contagious disease? Y N

Do you wear a pacemaker? Y N

Do you have chronic back pain? Y N

Do you bruise easily? Y N

Do you take aspirin or blood thinners? Y N

Do you suffer from asthma? Y N

Are you pregnant or nursing? Y N

Have you ever had surgery? Y N

Was surgery performed with the last 30-days? Y N

Do you have any herniated disks? Y N

Any problems with sleeping or sleeping disorder? Y N

Do you exercise/work-out on a weekly basis? Y N

How do you reduce stress? _____

All the above is true and correct to the best of my knowledge, _____.

Client's Initials

Printed name: _____

Client Signature: _____

Date: _____

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