Vegas Muscle Therapy
Client Intake Form

(please print)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____

❑ Referral Referred by: _____

Medical History

Medications: _____

_____

_____

Please check off all that apply:

- ❑ Headaches
- ❑ Cancer
- ❑ Heart/Circulation Problems
- ❑ Major Accident
- ❑ Neck/Back Injuries
- ❑ Numbness
- ❑ Allergies
- ❑ TMJ
- ❑ Joint Surgery
- ❑ Varicose Veins
- ❑ Diabetes
- ❑ Sprains/Strains
- ❑ Arthritis, tendonitis
- ❑ Abnormal Skin Condition
- ❑ High/Low Blood Pressure
- ❑ Blood Clots
- ❑ Fibromyalgia
- ❑ Recent Injuries

Information regarding conditions above :

_____

_____

_____

_____

Signature: _____ Date: _____