[Your Business Name]

Veteran & Clinical Massage Therapy Intake Form

Mission: *To restore health and improve lives through dedicated, therapeutic care.*

I. PERSONAL INFORMATION

- **Name: _____ Date: _____**
- **Phone: _____ Email: _____**
- **Emergency Contact: _____ Phone: _____**
- **Branch of Service (Optional): _____**

II. MEDICAL & SERVICE HISTORY

- **Primary reason for today's visit: _____**
- **Please list any service-related injuries (orthopedic, shrapnel, etc.):**

  _____

- Are you currently under a doctor's care for any chronic conditions?
  (e.g., High Blood Pressure, Diabetes, Heart Conditions, Arthritis)

  _____

- **Please list any recent surgeries or hardware (pins, plates, etc.):**

  _____

- **Do you experience any of the following? (Circle all that apply):**
  - Chronic Pain | Numbness/Tingling | PTSD | Insomnia | Limited Mobility | Anxiety

III. PREFERENCES & SAFETY

- **Pressure Preference:** [ ] Light [ ] Medium [ ] Deep [ ] Clinical/Targeted
- **Sensory Preferences:** (e.g., Light levels, music volume, or total silence)

  _____

- **Trauma-Informed Care:** To ensure your comfort, are there any specific areas to avoid, or any "startle triggers" (loud noises, sudden touch) I should be aware of?

  _____

IV. CONSENT & WAIVER

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension, and circulation improvement. I acknowledge that the therapist is not a doctor and does not diagnose illness or prescribe medication. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.

Signature: _____ Date: _____