Client Intake Form – Therapeutic Massage- Confidential

Personal Information

Name _____ Date of Birth_____

Address_____

State_____ City_____ Home Phone _____ Email_____

Work Phone _____ Occupation _____

Emergency Contact_____ Phone _____
Primary Physician_____ Phone _____

Massage Information

Have you ever received massage therapy? _____Yes _____No

If yes, how often do you receive massages? _____

If yes, do you have a style or pressure preference? ____Yes ____No

Specify: light pressure____ medium pressure_____ deep pressure_____ trigger point work____ nerve strokes____ energy work_____

Do you have any allergies to:

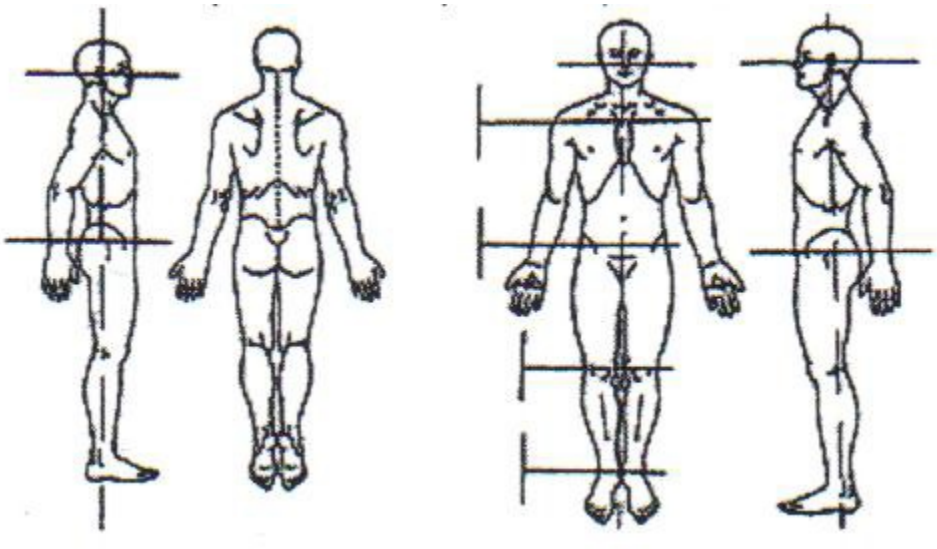
____ Medications	**_____ Food(Nuts, etc)**	**____Essential Oils**

_____environmental allergens (dust, pollen, fragrances)
_____reactions to skin care products

If any of the above are checked, please give details:
_____
_____

Are you wearing: _____ Contact Lenses _____Earring Aids ____ Hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session?

_____
_____
_____

Medical History

Are you currently taking any medications? _____Yes _____No

If yes, please list name and reason for medication:

_____
_____

Are you currently seeing a healthcare professional? _____Yes _____No

Do you see a chiropractor? ____Yes ____No If yes, how often? _____

If yes, please list names and reason/treatment:

_____
_____
_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

_____ Arthritis/Tendonitis	_____Depression, Panic Disorder, Other Psych Condition
_____Diabetes	_____Diverticulitis
_____Blood Clots	_____ Headaches/Migraines
_____Broken/Dislocated Bones	_____Heart Condition/Circulation Problems

____ Vertebrobasilar insufficiency	_____ Loss of bowel/bladdercontrol
_____Bruise Easily	_____ Neck/Back Problems
_____Cancer	_____High/ Low blood pressure
_____Chronic Pain	_____Recent Injury
_____Constipation/Diarrhea	_____muscle strain/sprain
_____Auto-immune Condition*	_____Pregnancy
_____Hepatitis (A, B, C, other)	_____Scoliosis
_____ Abnormal Skin Conditions	_____Seizures
_____Stroke	_____Whiplash
_____Surgery/Joint Replacement	_____Chemical dependency (alcohol, drugs)
_____TMJ disorder	_____ Major Accident
_____ Degenerative/Fragile Bone Disorder	_____ Allergies/Sensitivity
_____Lack of or reduced sensation/feeling	_____ Disk Problems

_____ Sciatica _____ Stiff/Painful/Swollen Joints

_____ Scoliosis	_____ Dizziness
_____ Dislocations/subluxations	_____Kidney disease

(*AIDS, fibromyalgia, chronic fatigue, lupus, Crohn's Disease etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so:

_____
_____
_____

Do you suffer from chronic or persistent pain/discomfort? ____Yes ____No
If so, for how long?_____

Do you know what causes/caused it or when the symptoms seem to get worse or better?

_____
_____
_____

Do you have any of the following today:

___skin rash	___cold/flu	___open cuts	___severe pain
___anything contagious	___injuries/bruises	___acute inflammation/infection	

If you are currently experiencing a cold, flu or fever, your session MUST be rescheduled for 48 hrs after symptoms subside.
Comments_____
_____

Please indicate your consumption of the following on a scale of 0-5 (5 being heavy):
Tobacco ____ Alcohol____ Caffeine_____ Exercise_____ Water_____ Sugar_____

Patient Consent for Treatment

Please read and sign below.

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature _____ Date _____
Practitioner Signature _____ Date _____

If under 17, signature of parent/guardian_____ Date_____