Client Intake Form for Massage Therapy

All information that you provide is confidential. **PLEASE PRINT**

Name _____Date _____Date of Birth _____Cell Phone _____

Address _____ Home Phone _____
Street City State Zip

Referred by or heard about us_____ Email Address _____

Occupation _____ Employed by _____Work# emergency only_____

Emergency Contact Person _____ Relationship to you_____# _____

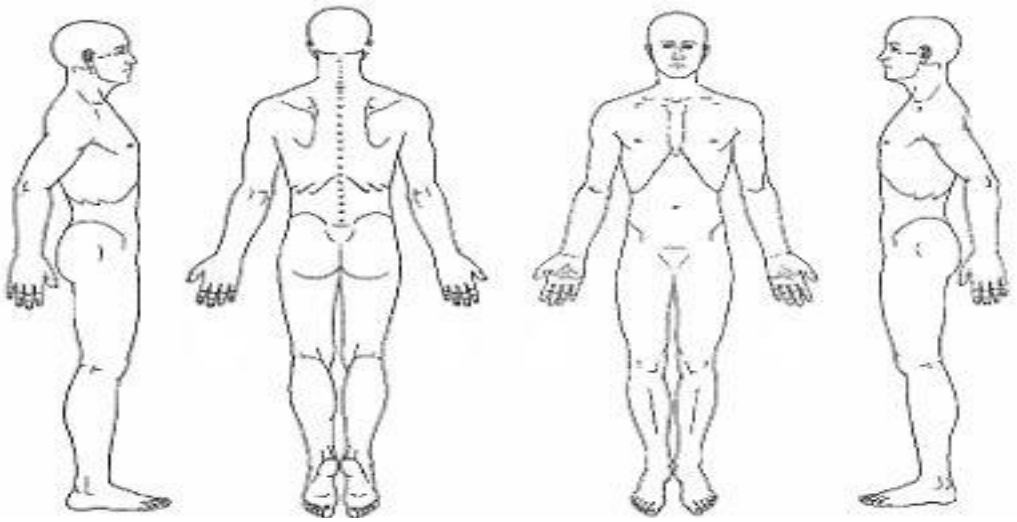
Primary Physician_____ Physician Phone_____

Have you ever received a professional massage? ___Yes __No Type/frequency _____

What is the main reason you want to receive a massage? _____

Date of last massage _____ _____

Mark the area(s) where you experience pain, tension, numbness, tingling, spasms, or cramps, or that need particular attention.



RIGHT BACK FRONT **LEFT**

Please check the areas of your body that you give permission to receive massage: _____ ALL LISTED

___ Neck ___Back ___Legs ___Feet ___Buttocks ___Arms ___Hands ___Upper chest ___ Head ___Face

Do you have any rashes, burns, tumors, warts, varicose veins, bruise easy or abrasions? NO _____ YES _____
_____

Do you have skin sensitivities or skin allergies? __NO __YES Type _____

Are you currently under any doctor's care? __NO __YES If yes, for what condition? _____
_____

List ANY surgeries and the year.
_____
_____
_____

List ANY accidents (including auto) and/or Injuries and the year _____
_____
_____

Health History: please **mark** any of the following that **apply** to you & if you are **taking MEDs** for them.

MUSCULO-SKELETAL	MED
__ bone or joint _____	____
__ tendonitis_____	____
__ bursitis_____	____
__ broken/fractured bones _____	____
__ arthritis_____	____
__ sprains/strains_____	____
__ low back, hip, leg pain_____	____
__ neck, shoulder, arm pain_____	____
__ headaches/migraines _____	____
__ spasms/cramps_____	____
__ jaw pain/ TMJ_____	____
__ other _____	____
CIRCULATORY	
__ heart condition _____	____
__ varicose veins _____	____
__ blood clots_____	____
__ high blood pressure _____	____
__ low blood pressure _____	____
__ lymphedema _____	____
__ breathing difficulty _____	____
__ sinus problems _____	____
__ allergies _____	____
__ other _____	____
INFECTIOUS DISEASE	
__ disease name(s)	
_____	____

	MED
SKIN	
__ allergies_____	____
__ rashes_____	____
__ **athletes foot** _____	____
__ **warts**_____	____
__ other_____	____
NERVOUS SYSTEM	
__ herpes/shingles_____	____
__ numbness/tingling_____	____
__ chronic pain _____	____
__ fatigue _____	____
__ sleep disorders _____	____
__ other _____	____
REPRODUCTIVE	
__ pregnant? Stage _____	____
__ other_____	____
OTHER	
__ cancer/tumors_____	____
__ diabetes_____	____
__ depression_____	____
__ drug/alcohol addiction_____	____
__ nicotine/caffeine addiction _____	____
__ Other _____	____

List OVER the COUNTER medications, including aspirin, ibuprofen, etc…. _____
_____

I understand that the treatment I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension, or for increasing circulation of energy flow. If I experience ANY pain or discomfort during the massage session, I will immediately inform the massage therapist.

I have disclosed all health information truthfully and in full.

I understand that the massage therapist does not diagnose diseases, illnesses or any other physical or mental disorders. Also, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I also understand that if at any time during the massage, with legitimate cause (sexual misconduct will NOT be tolerated) the therapist may end the session. I will still be responsible for full payment of the massage session & may not return.

____ Payment for services rendered is due at the time of service. Cash or personal checks accepted. No charges or
initial "on accounts" will be allowed. **There will be a thirty dollar ($30) charge for each returned check.**

____ **Cancellation policy requires a twenty-four (24) hour notice for scheduling purposes.**
initial **I agree to full payment of scheduled services for late cancellations and no shows.**

I have read and understand the above.

Client's Signature _____ Date _____
Or Parent Signature if a minor