

Client Intake Form- Therapeutic Massage & Bodywork

Personal Information

Name _____ Phone _____

Mailing Address _____ Date Of Birth _____

Occupation _____ Email _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____ Would you like an email notification for news and special offers? Y N

The following information will be used to help plan safe and effective massage sessions. It will be kept confidential.

Medical Information

1. Are you taking any medications? yes no

Please list: _____

2. Are you currently pregnant? yes no

If yes, how far along? _____

Any high risk factors? _____

3. Have you had any past/recent surgeries that may affect your massage? yes no

If yes, indicate what surgery and when it took place:

4. Do you currently have any implanted medical devices?

yes no If yes, indicate where the device is located and when it was placed:

5. Check any conditions that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tendinitis |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> HeartCondition |
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> TMJ Disorder | <input type="checkbox"/> DVT |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Plantar Fasciitis |
| <input type="checkbox"/> Anxiety/Depression/PTSD | |

6. Do you have trouble lying on your back, front or sides?

yes no _____

7. Do you sit for long hours at a workstation, computer, or driving?

yes no _____

8. Is there any other medical information or history that would be useful for your massage therapist to know?

Massage Information

9. Have you had a professional massage before? yes no

How recently? _____

10. Do you know what pressure you prefer?

Light Medium Firm

11. Check the areas you **are** comfortable having treated:

gluteals (buttocks) pectorals (chest) scalp face

feet hands abdomen adductors (inner thigh) hips

12. Do you have any skin allergies or sensitivities to lotions or oils?

yes no _____

13. Are there any areas (feet, face, abdomen, hands etc.) you do not want massaged? yes no

Please indicate: _____

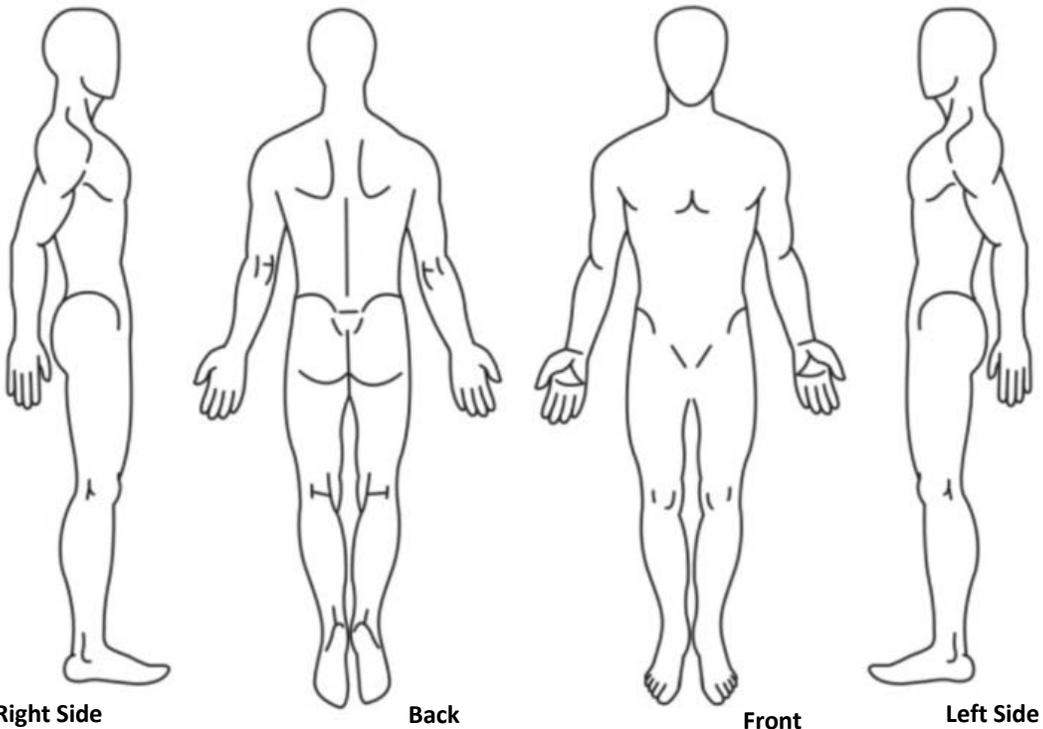
14. Do you have any specific goals or concerns for massage therapy and bodywork?

There will be a drape (sheet/blanket) over the breasts, the genital area and gluteal cleavage for all clients at all times.

Any gluteal massage or bodywork will be performed over the drape.

Any pectoral massage or bodywork will be performed over or just above the drape.

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Please indicate the areas you would like your massage therapist to concentrate on using the body chart or explain here:

Informed Consent & Liability Release

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Understanding all of this, **I give my consent to receive care.**

Client Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____