Massage Client Intake

Personal Information

Name_____ Date of Birth_____ Phone_____

Address_____ City/State/Zip_____

Email_____ Occupation_____

Emergency Contact Name_____ Relationship_____ Phone_____

How did you hear about us?_____

Medical Information

Are you currently taking any medications? Yes☐ No☐

If yes, please list name and use:_____

_____

Are you currently pregnant? Yes☐ No☐

If yes, how far along?_____

What makes it better?_____

_____

What makes it worse?_____

_____

Have you been in an auto accident/ Work injury in the last 30 days? Yes☐ No☐

If yes, please explain?_____

_____

Please indicate any of the following that apply to you.

☐Cancer
☐Headaches/ Migraines
☐Arthritis
☐Diabetes
☐Joint Replacement(s)
☐High/Low Blood Pressure
☐Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Please explain any conditions you have marked above:

_____

_____

Massage Information

Have you had a professional massage before? Yes☐ No☐

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

What pressure do you prefer?

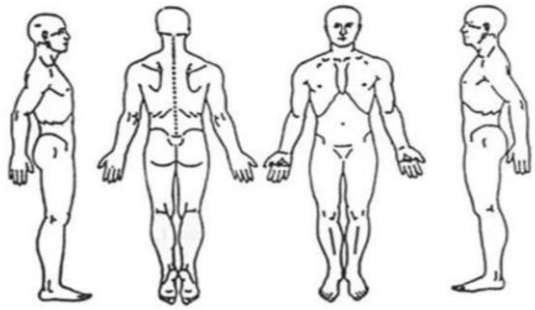
☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities to lotions/ oils?

☐ Yes ☐ No If yes, please explain_____

_____

Please circle any area of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. All minors must have signed consent by a legal guardian and minors under 17 must have a parent present during the entire session.
*Draping will be used during the entire session- only the area being worked will be uncovered. *

Client Signature_____

Date_____

Are you interested in our massage memberships? ☐ Yes ☐ No

Are you interested in seeing if your health insurance covers massage? ☐ Yes ☐ No

I understand that the massage I receive is provided for the basic purpose of relaxation of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.