Massage Therapy

CLIENT INTAKE FORM

Name _____ Phone _____ Today's Date _____

Address _____ Date of Birth _____

Email address _____ Occupation _____

Emergency contact _____ Relationship _____ Phone _____

Whom may we thank for your referral? _____

**Please answer the questions below.

Reason for initial visit? _____

Have you received massage therapy before? ☐ Yes ☐ No Frequency _____ last session _____

Goals for treatment _____

_____

Are you on any medication or OTC? ☐ Yes ☐ No for _____

_____

Do you exercise? ☐ Yes ☐ No If yes, how many times per week ? _____ How many hours? _____

How would you rate your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you perform any repetitive motion in your work, sports, or hobby? _____

_____

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

_____

Do you experience stress in your work, family or other aspects of your life? _____

_____

Are you experiencing tension, stiffness, discomfort or pain? _____

_____

Have you recently had an injury, surgery, or areas of inflammation? _____

_____

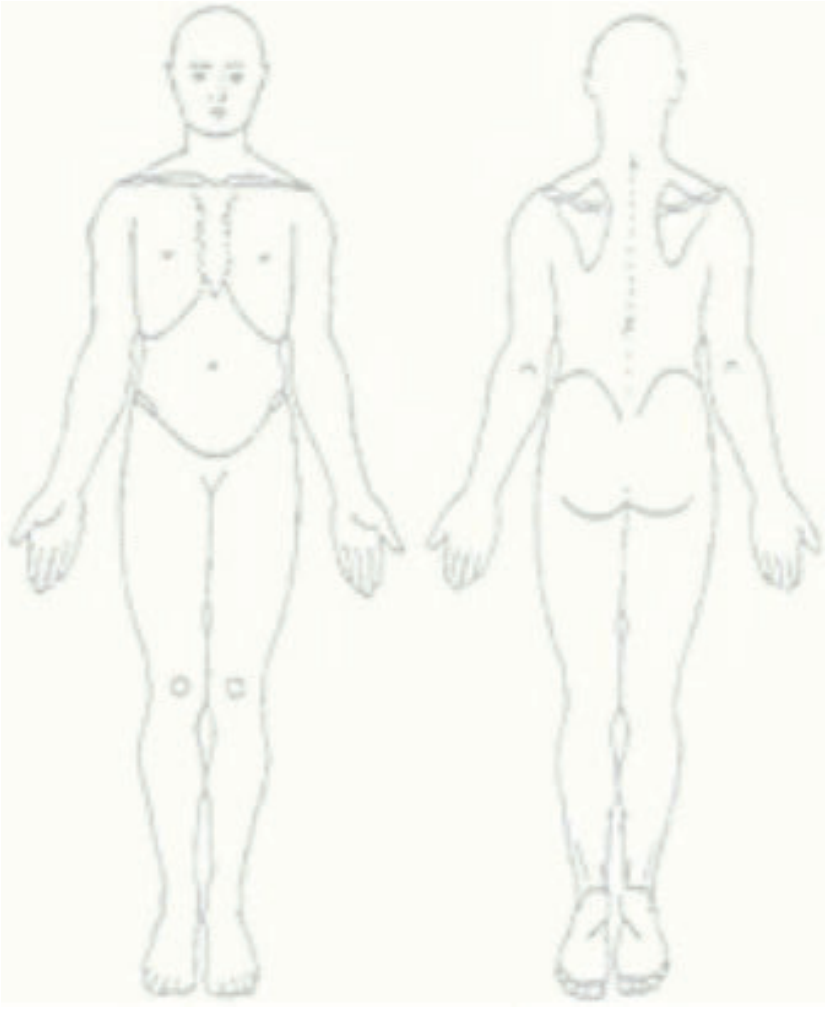
Do you have sensitive skin? ☐ Yes ☐ No Do you have a sensitivity to heat? ☐ Yes ☐ No

Do you have any allergies to oils, lotions or ointments? ☐ Yes ☐ No _____

_____

Please list all accidents where an injury(ies) occurred and all surgeries within the past five (5) years. In addition please list anything else you would want your therapist to know about your health history and current condition(s) before proceeding with your session including but not limited any serious illnesses, any allergies or hypersensitivities

****Please mark areas that cause discomfort**



**Please mark any of the following conditions you may currently have or have had

- Fever within 24 hours
- Headaches/Migraines
- Vertigo/Dizziness
- Ringing in Ears
- Hearing Loss
- Vision Problems
- Vision Loss
- Wear Contacts
- Wear Hearing Aids
- Neck Injury
- Jaw Pain/TMJD
- Trigeminal Neuralgia
- Bell's Palsy
- Dentures
- Whip Lash
- Asthma
- Allergies
- Sinusitis
- Bronchitis
- Emphysema
- Chronic cough
- Flu/Cold virus
- Breathing difficulty
- Frequent Colds
- Family Hx. of Respiratory problems
- Family Hx. of Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Heart attack
- Heart Disease
- Stroke
- Poor Circulation
- Thrombosis/ Blood Clots
- Embolism
- Lymphedema
- Hemophelia
- Alcohol within 24hrs
- Pace Maker
- Sports injury
- Phlebitis/Varicose Veins
- Chronic Congestive Heart Failure
- Bruises/Bruise Easily
- Chronic Pain
- Acute Pain
- Paralysis
- Seizures
- Epilepsy
- Multiple Sclerosis
- Parkinson's
- Shingles
- Numbness
- Tingling
- Sciatica
- Pinched Nerve
- Sensory loss/Change
- Emotional Change
- Grief Process
- Depression
- Anxiety
- Stress Syndrome
- Psychiatric Disorder
- Psychiatric Treatment
- Pins
- Plates
- Wires
- Artificial Joints
- Carpal Tunnel
- Lupus
- Bone or Joint Disease
- Tendonitis/ Bursitis
- Osteoporosis
- Sports Injury
- Recent surgery, including cosmetic
- Arthritis/Gout
- Family Hx. of Arthritis
- Spinal Injuries/Problems
- Bladder issues/Kidney Alignment
- Infection/Ongoing Infections
- Open wounds
- Rashes
- Athletes Foot
- Tuberculosis
- HIV/AIDS
- Lyme Disease
- Psoriasis/Eczema
- Herpes/Coldsores
- Infectious Skin Conditions
- Any Other Skin Conditions not previously mentioned

_____

- Fibromyalgia
- Chronic Fatigue Syndrome
- Cancer/Tumors
- Unexplained weight loss/gain
- Diabetes
- IBS/Crohns/Colitis/Ulcers
- GERDs/Reflux
- Other Digestive conditions

_____

- Currently on Medications
- Drug/Alcohol/Tobacco/E-cigs, etc.
- Epidural
- Pregnant
- C-sections or other scars
- Ovarian/Menstrual Problems
- BPH
- Any other Medical Condition(s)

_____

***Informed Consent: Please take a moment to carefully read the following and sign where indicated.**

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Because massage is contraindicated for some serious medical conditions, it may be necessary to obtain a doctor's release or prescription before beginning massage therapy. I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis or treatment, and that I should see a medical or chiropractic physician or other healthcare specialist for my condition. I agree to update the massage therapist in regards to changes in my health and understand that there shall be no liability on the therapist should I forget to do so.

I understand that:

- **Massage therapy is for the purpose of of stress reduction, relief from muscular tension or spasm, or for increasing circulation**
- **There is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments**
- **The massage therapist does not diagnose illness, disease or any mental disorder**
- **The massage therapist does not prescribe medical treatment nor perform spinal manipulations**
- **All information that I provide will be kept confidential as required by law**
- **My body will be properly draped at all times for comfort, security and warmth**
- **I will inform the therapist of any discomfort, so that the application of pressure or stroke may be adjusted to my level of comfort**
- **The massage is solely for the purpose of therapeutic massage**
- **The massage therapist also has the right to be free from any unwanted, harmful, offensive and/or physical contact or behavior. This will undoubtedly result in the termination of the session**
- **The potential benefits of massage as well as the discomfort I may feel have been explained**
- **Should I have to cancel an appointment for any reason, I agree to give the therapist a 24 hour notice as this time has been specifically set aside for me.**
- **There is a $25 fee for no show appointments**
- **By signing this form, I give consent to future sessions.**

Signature _____ **Date** _____