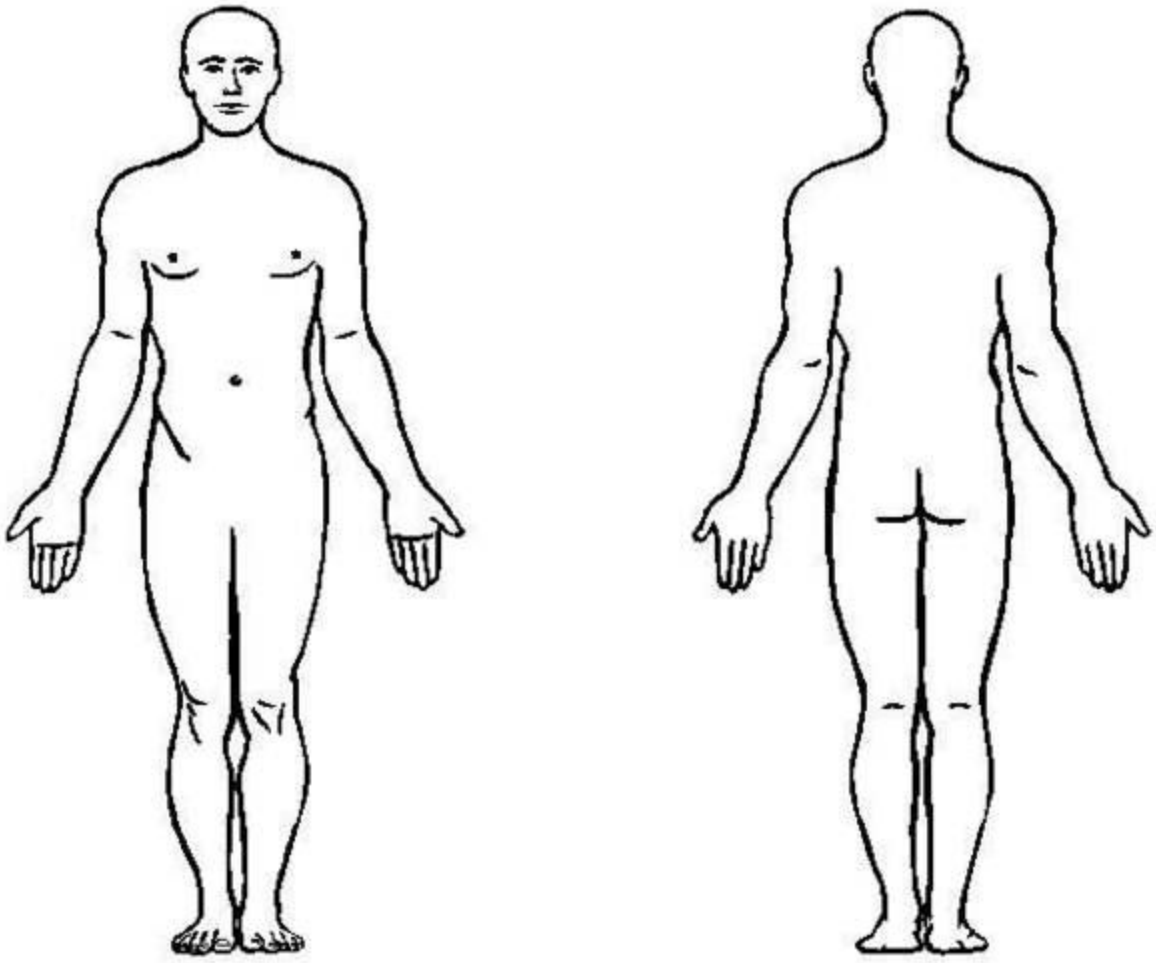
Client Intake Form - Therapeutic Massage

Name:_____Occupation:_____
Date of Birth:___/___/____ Email:_____
Address:_____
City/State/Zip:_____
Home phone:_____ Cell phone:_____
Emergency contact:_____Phone:_____
Referred by:_____
How did you hear about us?_____

Massage experience
Have you had a professional massage before? ____YES ____NO
What type of massage are you seeking?
Relaxation ( ) Therapeutic ( ) Other ( )
_____

Date of initial visit: ___/___/____
1.Do you have any difficulty lying on your front, back, or side?
__YES___NO
If yes, please explain_____
2.Do you have any allergies to oils,lotions, or ointments? ___YES ___NO
If yes please explain_____
3.Are you wearing contact lenses ( ) dentures ( ) hearing aid ( ) ?
4.Do you sit for long hours at a workstation, computer or driving? ___Y/N
If yes please explain_____
5.Do you perform any repetitive movement ? ___Y/N
If yes please explain_____
6.How you would you rate your current level of stress (from 1 to 10)
If yes, how do you think it has affected your health?
Muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) digestive issues ( )
Other_____

7.Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort: ____Y/N
If yes please identify_____
What are your initial goals for treatment?
_____
Circle any specific areas you would like the massage therapist to concentrate on during the session:



Draping will be used during the session - only the area worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17. I, _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to mu 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.

Signature of the client _____Date___/___/____

Medical History

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use _____

_____

Do you see a chiropractor? ____Y/N

If yes, how often? _____

Are you currently pregnant? ☐ yes ☐ no

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____ What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? ☐ yes ☐ no If yes, please list:

_____

Please indicate any of the following that apply to you:

☐ Cancer ☐ Headaches/Migraines ☐ Arthritis ☐ Diabetes ☐ Stroke
☐ Joint Replacement(s) ☐ High/Low Blood Pressure ☐ Neuropathy
☐ Fibromyalgia ☐ Heart Attack ☐ Kidney Dysfunction ☐ Epilepsy
☐ Deep vein thrombosis/Blood Clots ☐Varicose veins ☐ Numbness
☐Sprains or Strains ☐ Contagious skin condition ☐ Recent accident or injury

Explain any conditions you have marked above:

_____

_____

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.

Client Signature _____ Date _____

CONSENT FORM
MASSAGE ON A MINOR

I, _____,am the parent or guardian having legal custody of
Parent or Legal Guardian

_____. I hereby authorize _____
Minor Client *Massage Practitioner*

to administer massage treatment. I verify that the minor client is of sufficient age and aptitude as to provide verbal and written feedback to the practitioner before, during and after the massage.

I understand that I am welcome and encouraged to remain in the area where the massage is being administered. Once the massage has actually started, I agree to remain in the room to avoid distracting the recipient or practitioner. I further understand that as the parent/guardian, I have the right to place any conditions on the environment and massage on behalf of the minor. I agree to list those below in the space provided.

Signature _____
Parent or Legal Guardian Authorized Adult Custodian

Phone (Home or Cell) _____ Date_____

Signature _____ Date _____
Massage Practitioner