CONFIDENTIAL CONFIDENTIAL

MASSAGE CLIENT INTAKE FORM

Personal Information:

NAME: _____ BIRTH DATE: _____

STREET: _____ OCCUPATION: _____

CITY: _____ STATE: _____ ZIP: _____ WORK PHONE: _____

EMAIL ADDRESS: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ CONTACT'S PHONE NUMBER: _____

WOULD YOU LIKE TO BE ON OUR MAILING LIST? _____YES _____ NO **IF YES:** _____Postal _____Email _____BOTH

HOW DID YOU HEAR ABOUT US?_____

Massage Experience:

HAVE YOU HAD A PROFESSIONAL MASSAGE BEFORE? ☐ YES ☐ NO **IF YES**, FREQUENCY OF MASSAGES? _____

WHAT DO YOU ENJOY MOST ABOUT MASSAGE? _____

ARE THERE ANY AREAS (FEET, FACE, ABDOMEN, ETC.) YOU DO NOT WANT MASSAGED? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

WHAT PRESSURE DO YOU PREFER? ☐ LIGHT ☐ MEDIUM ☐ DEEP

ARE YOU WEARING: ☐ CONTACT LENSES? ☐ DENTURES? ☐ HEARING AID(S)?

Current Health:

ARE YOU CURRENTLY UNDER MEDICAL SUPERVISION? ☐ YES ☐ NO **IF YES**, PLEASE EXPLAIN: _____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO **IF YES**, PLEASE LIST: _____

_____

DO YOU HAVE ANY ALLERGIES TO OILS, LOTIONS OR OINTMENTS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN AND LIST ANY KNOWN ALLERGIES: _____

HEIGHT & WEIGHT _____ DO YOU EXERCISE REGULARLY AND/OR PARTICIPATE IN ANY SPORTS? ☐ YES ☐ NO

IF YES, WHAT KIND OF EXERCISE/SPORTS? _____

PLEASE EXPLAIN ANY REPETITIVE MOVEMENT YOU ARE REQUIRED TO MAKE IN YOUR WORK, SPORTS OR HOBBY?

_____

DO YOU SIT FOR LONG HOURS AT A WORKSTATION, COMPUTER OR DRIVING? ☐ YES ☐ NO

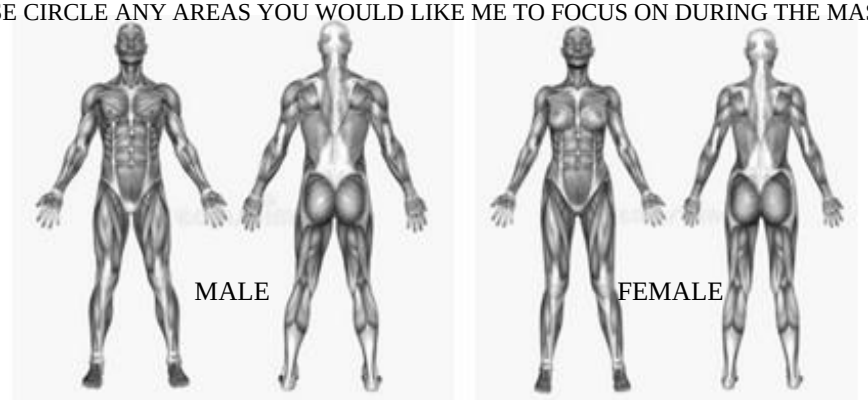
ARE YOU CURRENTLY EXPERIENCING STRESS IN YOUR WORK, FAMILY OR OTHER ASPECT OF YOUR LIFE? ☐ YES ☐ NO

ARE YOU EXPERIENCING TENSION, STIFFNESS, DISCOMFORT OR PAIN ☐ YES ☐ NO

HAVE YOU RECENTLY HAD AN INJURY, SURGERY, OR AREAS OF INFLAMMATION? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

PLEASE CIRCLE ANY AREAS YOU WOULD LIKE ME TO FOCUS ON DURING THE MASSAGE:



Health History:

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOU:

MUSCULOSKELETAL
-Bone or Joint Disease
-Tendonitis/Bursitis
-Tennis or Golfer's Elbow
-Carpal Tunnel Syndrome
-Arthritis/Gout
-Jaw Pain/TMJ
-Lupus
-Spinal Problems
-Migraines/Headaches
-Osteoporosis
-Artificial Joint
-Fibromyalgia/Connective Tissue Disease

CIRCULATORY
-Heart Condition
-Phlebitis/Varicose Veins
-Blood Clots
-High/Low Blood Pressure
-Lymphedema
-Thrombosis/Embolism

RESPIRATORY
-Breathing Difficulty/Asthma
-Emphysema
-Allergies, specify:
_____
-Sinus Problems

NERVOUS SYSTEM
-Shingles
-Numbness/Tingling
-Pinched Nerve
-Neuropathy
-Chronic Pain
-Paralysis
-Multiple Sclerosis
-Parkinson's Disease

REPRODUCTIVE
-Pregnant, stage_____
-Ovarian/Menstrual Problems
-Prostate

SKIN
-Allergies, specify:
_____
-Rashes
-Cosmetic Surgery
-Athlete's Foot
-Herpes/Cold Sores
-Open Sores or Wounds
-Easy Bruising

DIGESTIVE
-Irritable Bowel Syndrome
-Bladder/Kidney Ailment
-Colitis
-Crohn's Disease
-Ulcers

PSYCHOLOGICAL
-Anxiety/Stress Syndrome
-Depression

OTHER
-Cancer/Tumors, specify:
_____
-Diabetes
-Drug/Alcohol/Tobacco Use
-Epilepsy
-Seizures or Loss of Consciousness
-Contagious Conditions:
_____

Please explain and/or list any other medical condition(s) not listed. Also, any additional information you may want to share about your health:
_____
_____
_____
_____

Client Agreement/Consent for Treatment:

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 further understand that massage/bodywork 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 of which I am aware. I understand that massage/bodywork 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/bodywork 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment. Treatments may be covered by extended health care plans. I understand that it is my responsibility to submit all claims that apply under my insurance coverage. Understanding all of this, I give my consent to receive care.

_____ _____
(PRINT NAME) (SIGNATURE)

_____ _____
(DATE) (GUARDIAN'S SIGNATURE - IF APPLICABLE)