Massage Intake Form

Name_____ **Date of birth**_____

Address_____

Phone #'s: Home_____**Work**_____**Cell**_____

Occupation_____

Primary Health Care Provider_____ **Phone:**_____

Emergency Contact_____**Phone:**_____

Have you ever received massage therapy? Yes or No Type_____

Please place a check for the following conditions that affect your health now or in the past:

_____**arthritis**
_____**broken/dislocated bones or joints**
_____**chronic pain**
_____**back problems**
_____**bruise easily**
_____**muscle strain/sprain**
_____**headaches**
_____**whiplash**
_____**scoliosis**
_____**heart attack**
_____**high blood pressure**
_____**blood clots/DVT**
_____**varicose veins**
_____**surgery**
_____**kidney disease**
_____**cancer or tumor**
_____**chemotherapy/radiation**
_____**constipation/diarrhea**
_____**diabetes**
_____**neuropathy/numbness**
_____**hepatitis**
_____**stroke**
_____**seizures**
_____**sinus problems**
_____**insomnia**
_____**TMJ disorder**

_____**skin conditions (rash, athlete's foot, warts, moles, acne, open wounds)**
_____**auto-immune conditions (AIDS, fibromyalgia, chronic fatigue, lupus, other)**
_____**depression, panic disorders, or other psychological conditions**
_____**chemical dependency (alcohol, drugs)**
_____**allergies (skin care products, nuts, other)**
_____**pregnancy (trimester 1, 2, or 3)**
_____**other**_____
_____
_____
_____

(over)

Are you currently being treated by a healthcare professional for the above conditions? Yes No

_____

_____

_____

_____

Current medications including over the counter pain relievers

_____

_____

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Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage work may be contraindicated. A referral from your primary care provider may be required prior to services being provided. I understand that the massage work 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy 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(s) given should be construed as such. Because massage therapy is contraindicated 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 forget to do so. It is also understood 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.

Client Interaction Policy

- **A 24 hour notice for canceling or rescheduling is required to avoid being charged.**
- **Arrive 15 minutes early to fill out necessary forms.**
- **Sessions begin and end at scheduled times.**
- **Sessions begun late due to the client arriving late end at the appointed time and are full price.**
- **Payment is expected at the time service is rendered.**

Signature _____ **Date**_____