Client Intake Form

Personal Information **Date of Initial Visit:**

Name: Home Phone: Cell Phone:
Address:
City/State/Zip:
Email: Date of Birth: Occupation:
Emergency Contact: Phone:

The Following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before?
   If yes, how often do you receive massage therapy
2. Do you have any difficulty lying on your front, back or side?
   If yes, please explain
3. Do you have any allergies to oils, lotions or ointments?
   If yes, please explain
4. Do you have sensitive skin?
5. Do you sit for long hours at a workstation, computer or driving?
   If yes, please describe
6. Do you perform any repetitive movement in your work, sports or hobby?
   If yes, please describe
7. Do you experience stress in your work, family or other aspect of your life?
   If yes, how do you think it has affected your health?
   () Muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other- Please Specify
8. Is there a particular area of the body where you are experiencing tension, stiffness, pain? or other discomfort?
   If yes, please identify
9. Do you have any particular goals in mind for this massage session?
   If yes, please explain
10. What is the preferred pressure you like in your massage? (1-lightest/10-deepest)
11: Please List the specific areas you would like the therapist to concentrate on the most Ex: shoulders, Neck, glutes, Lower/upper Back, Quads, Hamstrings, Feet, ect.

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

12. Are you currently under medical supervision?
    If yes, please explain
13. Do you see a chiropractor?
    If yes, how often?
14. Are you currently taking any medication?
    If yes, please list

15. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) atherosclerosis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?

Please explain any conditions that you have marked above

16. Is there anything else about your health history that you think would be useful for your Massage Practitioner to know to plan a safe and effective massage session for you?

Draping will be used during the session – only the area being worked on will be uncovered. Clients 17 years or under must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a 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 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.

Signature of Client _____ Date _____

Signature of Parent/Gaurdian _____ Date _____

Signature of Massage Therapist _____ Date _____

Cancellation Policy: *Out of courtesy to our guests & staff, we require 24 hours notice to cancel or reschedule any previously scheduled treatment, and 48 hours for packages and group functions. A 50% cancellation fee will be applied to the credit card or gift certificate used to secure the appointment in the absence of adequate notice. A no-show will be charged 100% of the service cost.*