Client In-Take Form

Name: _____ Birthdate: _____

Best contact #: _____ Text Message? Yes No

Address: _____

Email: _____ Referred by: _____

Occupation: _____ Hobbies/Activities: _____

Emergency Contact: _____ Phone #:_____

Have you ever had professional massage? Yes No

If yes, what kind and how often?_____

Do you have any difficulty laying on your front, back or side? Yes No

If yes, please explain: _____

Do you have any allergies/sensitivities to oils, lotions, ointments, or scents? Yes No

If yes, please explain: _____

Please identify the particular areas where you experience tension, pain, stiffness and/or other discomfort:

_____

_____

Please list your medications: _____

Please check any condition(s) listed below that have ever applied to you:

( ) headaches/migraines
( ) numbness/tingling
( ) easy bruising
( ) epilepsy
( ) artificial joint
( ) decreased sensation
( ) osteoporosis
( ) heart conditions, pacemaker, stint, shunt
( ) skin rashes
( ) Circulatory disorder
( ) scoliosis
( ) deep vein thrombosis/blood clots
( ) recent accident, injury, injection or surgery
( ) cancer
( ) implants of any kind within last 9 months
( ) eye procedures within last 72 hours
( ) pregnant (or trying)
( ) GI or kidney issues
( ) high or low blood pressure

Please explain any condition you have marked, INCLUDING, surgeries, accidents/injuries, and other medical conditions:

_____

_____

I _____, (print name) understand that the massage I receive is provided for the therapeutic measure used to reduce stress, muscular tension, and pain. 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 medial examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I'm aware. Massage should not be performed under certain medical conditions, I affirm that I have stated all 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 therapists part should I fail to do so. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made with my treatment I will inform the therapist, so she may adjust the treatment or recommend another course of treatment. I also understand that massage therapy is non-sexual in nature and any advancement made will terminate the massage. Clients under the age of 18 must be accompanied by an adult or legal guardian during the entire session. **I agree to abide by a 24-hour cancellation notice for any scheduled massage. I understand I may be charged up to the full amount of service for missed appointments or any cancellations with less than a 24-hour notice.**

Signature of Client/Guardian: _____ Date: _____