

CLIENT INTAKE FORM – MESSAGE ONLY

Personal Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Referred by: _____

Cell Phone: _____ Alt. Phone: _____ Work/Home

Do you consent to receive text message appointment reminders? Yes / No

Occupation: _____ Employer: _____

Emergency contact name and 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.*

Date of initial visit: _____

1. Have you had a professional massage before? Yes / No

If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back or side? Yes / No

If yes, please explain _____

3. Do you have any allergies to oils, lotions or ointments? Yes / No

If yes, please explain _____

4. Do you have sensitive skin? Yes / No

5. Are you wearing contact lenses/dentures/hearing aid?

6. Do you sit for long hours at a workstation, computer or driving? Yes / No

7. Do you perform any repetitive movement in your work, sports or hobby? Yes / No

If yes, please explain _____

8. Do you experience stress in your work, family or other aspect of your life? Yes / No

If yes, how do you think it has affected your health?

Muscle tension/Anxiety/Insomnia/Irritability/Other: _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes / No

If yes, please identify _____

10. Do you have any particular goals in mind for your massage session? Yes / No

If yes, please explain _____

Medical History

11. Are you currently under medical supervision? Yes / No

If yes, please explain _____

12. Do you see a chiropractor? Yes / No If yes, how often? _____

13. Are you currently taking any medications? Yes / No

If yes, please list _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> easy bruising |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> recent fracture | <input type="checkbox"/> recent surgery |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> swollen glands | <input type="checkbox"/> current fever |
| <input type="checkbox"/> back/neck problems | <input type="checkbox"/> headache/migraine | <input type="checkbox"/> sprains/strains |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> heart condition |
| <input type="checkbox"/> deep vein thrombosis/blood clots | <input type="checkbox"/> varicose veins | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> atherosclerosis | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> artificial joint |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> diabetes | <input type="checkbox"/> cancer |
| <input type="checkbox"/> decreased sensation | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> tennis elbow | |
| <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis | | |
| <input type="checkbox"/> pregnancy – if yes, how many months? _____ | | |

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that your massage therapist should be aware of? _____

I, _____ (print name) understand that the massage I receive is provided for the purpose of relaxation and relief of muscular tension or spasm, reduction of scar tissue or chronic 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 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 of 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 _____

Consent to Treatment of Minor: By my signature below, I hereby authorize the massage therapist to administer massage or bodywork therapy techniques to my child or dependent as deemed necessary.

Signature of Parent/Guardian _____ Date _____

Massage Policies

ARRIVAL TO YOUR MASSAGE

For your first appointment, please arrive 15 minutes prior to the scheduled start time. This allows for time to complete any forms and prepare for your massage. After your first appointment, please arrive five minutes prior to your scheduled start time. Early arrival allows for a relaxed and unhurried experience.

If late arrival is inevitable, your massage may need to be shortened in order to stay on schedule. The original treatment times will be charged.

RESPECT FOR CLIENT NEEDS

The massage therapists are happy to adjust pressure, temperature, music volume, working longer on an area or move on if requested.

The client may choose to leave on as much clothing as needed for comfort, refuse any massage methods, stop massage at any time and is free to leave.

The client will always be modestly draped. Only the area being massaged will be undraped.

Occasionally, an emotional response to massage occurs. If this happens, it is okay to express the feelings in our safe, nonjudgmental environment – or you may request privacy and end the session.

CONFIDENTIALITY AND CONVERSATION

The discussion between the massage therapist and the client is confidential. The client may or may not choose to talk during the massage.

HEALTH AND SAFETY

It is very important both for your health and the safety of the therapist that you arrive for your appointment without the influence of alcohol or recreational drugs, so that you may be fully aware of how the massage is affecting your body.

Please be aware that sexual behavior, including comments or gestures, is not appropriate here and will not be tolerated. You and your therapist have the right to terminate the session at any time.

CANCELLATION/NO SHOW POLICY

Please provide at least 24 hours notice if you need to reschedule or cancel a massage. If a client fails to cancel within 24 hours, a missed appointment fee of \$35 will be applied.

If a client is a no show or has a pattern of missed appointments, they may be required to pre-pay for services prior to booking future appointments.