

Client Intake Form – Therapeutic Massage

Personal Information:

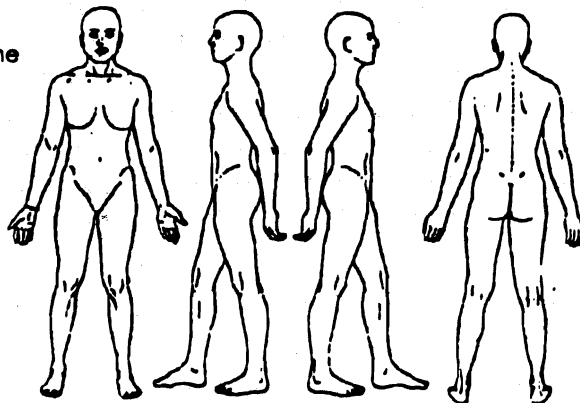
Name _____ Phone (Day) _____ Phone (Eve) _____
 Address _____
 City/State/Zip _____
 email _____ Date of Birth _____ Occupation _____
 Emergency Contact _____ Phone _____

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

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 () a hearing aid () ?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
 If yes, please describe _____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
 If yes, please describe _____
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 this massage session? Yes No
 If yes, please explain _____

Circle any specific areas you would like the
 massage therapist to concentrate on
 during the session:



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Medical History

In order to plan a massage session that is safe and effective, I need some general information about your 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 medication? 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"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> pregnancy If yes, how many months? |
| <input type="checkbox"/> atherosclerosis | |

Please explain any condition that you have marked above _____

15. 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 under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by 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 Massage Therapist _____

Date _____



POLICIES

Name _____ Date of Birth _____

I understand that unanticipated events happen in everyone's life. In consideration of my clients and my commitment to providing an outstanding massage experience, I have adopted the following policies:

ARRIVAL TO YOUR MASSAGE

For your first appointment, please arrive 10 minutes prior to the scheduled appointment time. This request allows time to complete the Client Intake Forms, change and prepare for your massage. After your first appointment, please arrive five (5) minutes prior to the scheduled appointment time. Early arrival allows for a relaxed and unhurried experience.

CANCELLATION POLICY

Please provide at least **24 hours notice** if you need to reschedule or cancel your massage. This allows the opportunity for someone else to schedule an appointment that may be waiting patiently on the wait list. **Any cancellations with less than 5 hours notice are subject to a fee of 50% of the cost of scheduled service.**

LATE ARRIVAL POLICY

I regret that late arrivals will not receive an extension of scheduled appointments. In special cases and when the schedule will allow, I may be able to make an allowance for a partial or full appointment. Regardless, **you will be responsible for full session.**

NO SHOW POLICY

Clients who fail to show for appointments without giving any prior notification will be charged in full for the scheduled service. A payment over phone or in office will be required before next appointment is booked. To "No-Show, No-Call" is not fair to me nor the person waiting for an available appointment.

DRAPING

Clients will remain covered throughout the entire session.

Only areas being worked will be uncovered.

At no time during the session should the client try to remove the drape.

Signature of Client _____ Date _____

Signature of Massage Therapist _____ Date _____