

Client Intake Form - CONFIDENTIAL INFORMATION

Name: _____ E-mail: _____
 Address: _____ City/State/Zip: _____
 Phone: _____ Cell: _____ Birthday: ___/___/___
 Occupation: _____ Referred to this office by: _____
 Emergency contact: _____ Phone: _____

General and Medical Information

Y N Have you ever had a professional massage? If yes, what type? _____
 Y N Are you pregnant? If yes, how far along are you? _____
 Y N Are you currently taking any medications? _____
 Y N Are you currently seeing a healthcare professional? _____
 Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:

List of current medications and reason: _____

If currently seeing a helthcare professional, list names/ treatment: _____

Do you have any of the following today:
 ___ skin rash ___ cold/flu ___ open cuts ___ severe pain ___ anything contagious ___ injuries/bruises

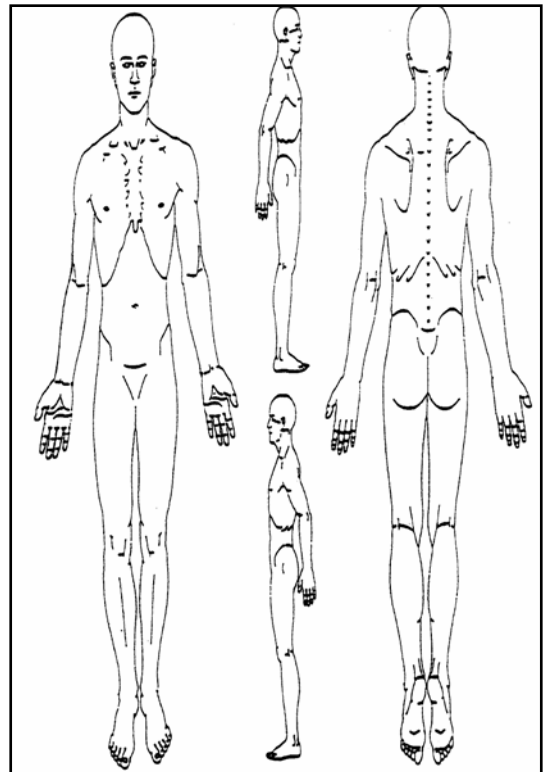
Do you have allergies to:
 ___ medications ___ foods (nuts, etc.) ___ environmental allergens
 ___ reactions to skin care products

If any of the above are checked, please give details:

Indicate Areas of Pain/Tension:

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

- | | |
|---|---|
| ___ Arthritis | ___ Depression, (panic disorder, other pshyc condition) |
| ___ Diabetes | ___ Diverticulitis |
| ___ Blood clots | ___ Headaches |
| ___ Broken/dislocated bones bruise easily | ___ Heart conditions |
| ___ Cancer | ___ Back problems |
| ___ Chronic pain constipation/diarrhea | ___ High blood pressure |
| ___ Auto-immune condition* | ___ Insomnia |
| ___ Hepatitis (A, B, C, other) | ___ Muscle strain/sprain |
| ___ Skin conditions | ___ Pregnancy |
| ___ Stroke | ___ Scoliosis |
| ___ Surgery | ___ Seizures |
| ___ TMJ disorder | ___ Whiplash |
| ___ (*AIDS, fibromyalgia, chronic Fatigue, lupus, etc.) | ___ Chemical (Alcohol, drugs) |



Please mark in the diagram above any areas where you have pain or discomfort.

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If any of the above needs to be detailed or if there is anything else to share, please do so:

Are you wearing: ___contact lenses ___hearing aid ___hairpiece

What are your goals/ expectations for this therapy session? _____

Massage Client Waiver Form

Please take a moment to read and initial all of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session. _____

I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness. _____

I affirm that I have notified my therapist of all known medical conditions and injuries. _____

I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so. _____

I understand that massage is entirely therapeutic and non-sexual in nature. You will maintain proper coverage at all times. Any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. _____

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork. _____

Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully. _____

Information and Suggestions

- Prior to your massage, please remove contact lenses and all jewelry. Pull long hair back with a clip or band.
- In general, massage is given while you are unclothed. However, you may choose to wear undergarments or a swimsuit. You will be covered with a top sheet throughout your session. This is your massage and you should be as comfortable as possible.
- Feel free to ask your therapist any questions before, during, or after the session. Your therapist is a highly trained professional and will be happy to make you feel informed and comfortable.

I have received the policy statement, and have read and agree to the policies therein.

Client name: _____

Client signature: _____

Date: _____