Client Intake Form – Therapeutic Massage

Complete this top section if you have never been to this office. Otherwise move to Section B.

Name:_____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Birthdate: _____ Age: _____ Sex: M ☐F ☐

E-Mail:_____

Type of Work performing currently or performed in the past: _____

Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____

Spouse's Name: _____

Emergency Contact:_____ Phone Number: _____ Relationship: _____

How did you hear about our office?_____

Who may we thank for referring you to this office? _____

Section B

The following Information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? Yes No If yes, how often? __/year
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, ointments, fruits or nuts? Yes No

   If yes, please explain : _____
4. Do you have sensitive skin? Yes No

   If yes, please explain : _____
5. Do you wear: ____ contact lenses ____dentures ___a hearing aid ___prosthetics?
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

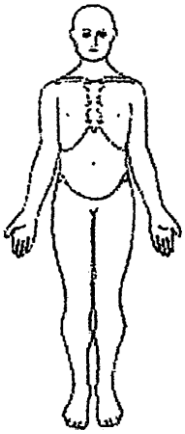
   If yes, please describe: _____
8. How do you feel the stress in your work, family, or other aspect of your life affected your health?

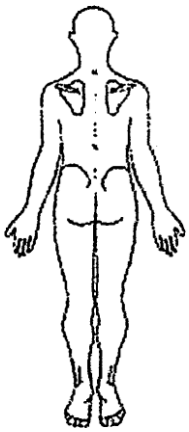
   ____muscle tension ___ anxiety ___insomnia ___irritability other:_____
9. Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort?

   If yes, where: _____
10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, where: _____

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





Medical History

Do you currently or have you ever had any of the following :(please check)

____phlebitis
___ joint disorder
____osteoporosis
____headaches/migraines
____diabetes
___ back/neck problems
___ TMJ
___ contagious skin condition
___ tennis elbow
___ recent surgery:_____
____sprains/strains
____swollen glands
____heart condition
____circulatory disorder
____atherosclerosis
____recent accident or injury

___ deep vein thrombosis/blood clots
___ rheumatoid arthritis/osteoarthritis/tendonitis
___ epilepsy
___ cancer
___ decreased sensation
____fibromyalgia
___ carpal tunnel syndrome
____open sores or wounds
___ recent fracture
___ artificial joint:_____
____current fever
____allergies/sensitivity
____high or low blood pressure
____varicose veins
____easy bruising
____pregnancy If yes, how many months? ___

Are you currently under medical supervision? Yes No

If yes, please explain: _____

· Do you see a chiropractor? Yes No If yes, how often?_____

Are you currently taking any medication? Yes No

If yes, please list _____

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

I 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 my 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 other qualified medical specialist for any mental or physical ailment that I am aware of. Understand that massage therapists are not qualified to perform 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 Therapist: _____ Date: _____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Client Name:_____ Signature of Client/Guardian: _____Date Signed:_____

Staff Witness:_____ Date:_____