Client Intake / Health Information

Date: _____

Personal Information:

Name: _____ D.O.B.: _____ Gender.: _____

Address: _____ City/State/Zip: _____

Marital Status: _____ Children's Names/Ages: _____

Occupation: _____ Employer: _____

Primary Contact #: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us?: _____

Medical Information:

Major ailment you want to improve: _____

_____

What brought it on?: _____

What makes it worse?: _____

Does it interfere with your: Daily Routine / Work / Sleep

What have you done for relief?: _____

Medical Diagnoses?: Yes / No X-Rays/MRI?: Yes / No

Are you taking any medications?: Yes / No

Please List/Attach: _____

Describe Exercise/Activities: _____

List Accidents/Operations/ Joint Replacements: _____

_____

List Allergies/Sensitivities: _____

Check the following conditions that apply to you, past and present:

- o Headaches / Migraines
- o Joints: Stiffness / Pain / Spasms / Cramps
- o Bones: Broken / Fractured / Sprained
- o Jaw Pain / TMJ
- o Tendonitis / Bursitis / Arthritis
- o Osteoporosis
- o Spinal Cord Injury
- o Concussion
- o Pregnancy: Current / Previous
- o PMS / Menopause
- o Lymphedema
- o Chronic Fatigue
- o Sleep Disorders
- o Diabetes
- o Fibromyalgia
- o Cancer
- o Other: _____

_____

- o Heart Condition
- o Stroke
- o Sinus Problems
- o Rashes / Warts
- o Athlete's Foot
- o Indigestion
- o Constipation
- o Intestinal gas / bloating
- o Diverticulitis
- o Irritable Bowel Syndrome
- o Cold Feet or Hands
- o Varicose Veins
- o Hearing Impaired
- o Visually Impaired
- o Depression
- o Drug use
- o Alcohol use
- o Nicotine use
- o Caffeine use

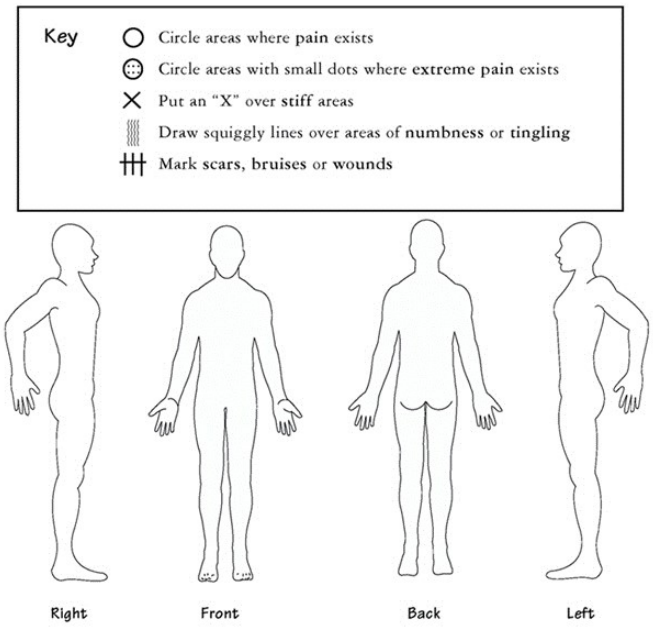
Massage Information:

Have you had a professional massage before? Yes / No

Preferred Pressure: Light / Medium / Deep

Are there any areas you do not want massaged (*face, feet abdomen, etc.*)?: Yes / No Please list: _____

Current Problem Areas: Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.



Additional comments:

_____

_____

_____

_____

Massage Therapy Informed Consent

I, _____, (*client*) understand that massage therapy provided by, _____, (*massage therapist*) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____

_____

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any ailments/condition I may have.

I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have stated all ailments/conditions that I am aware of and this information is true and accurate. I will inform the massage therapist of any changes in my status. Should I experience any pain or discomfort during the session, I immediately communicate that to the massage therapist so the treatment can be adjusted.

I understand and agree to abide by the following center policies:

Arrival, Reservations and Cancellations; We wish to treat all our clients with respect and in a timely manner and any late arrival may unfortunately deprive you of precious time from your session.

Your services and treatments are reserved and prepared especially for you. Because of our exclusivity and premium services, a strict cancellation policy will be upheld. A 50% fee is charged for cancellation and missed appointments without a minimum notice of 24 hours.

By signing below, you have agreed to the above:

Client Signature: _____ Date: _____

Parental Consent for Massage Therapy

I, _____, am the parent or legal guardian of _____
name of parent/legal guardian *name of minor*

I am aware of that my child is receiving massage therapy by _____ for the purposes listed here:
Name of Massage Therapist/Company

(example: relaxation, stress reduction, muscle spasms, soft tissue injury and pain, etc.)

_____

_____

I understand massage therapy is not intended to be or replace medical advice or medical treatment, and that I should consult with my child's primary care provider if I have any concern or questions about the appropriateness of massage.

_____ _____ _____
Signature of Parent/Guardian *Contact Phone Number* *Date*