Massage Intake Form

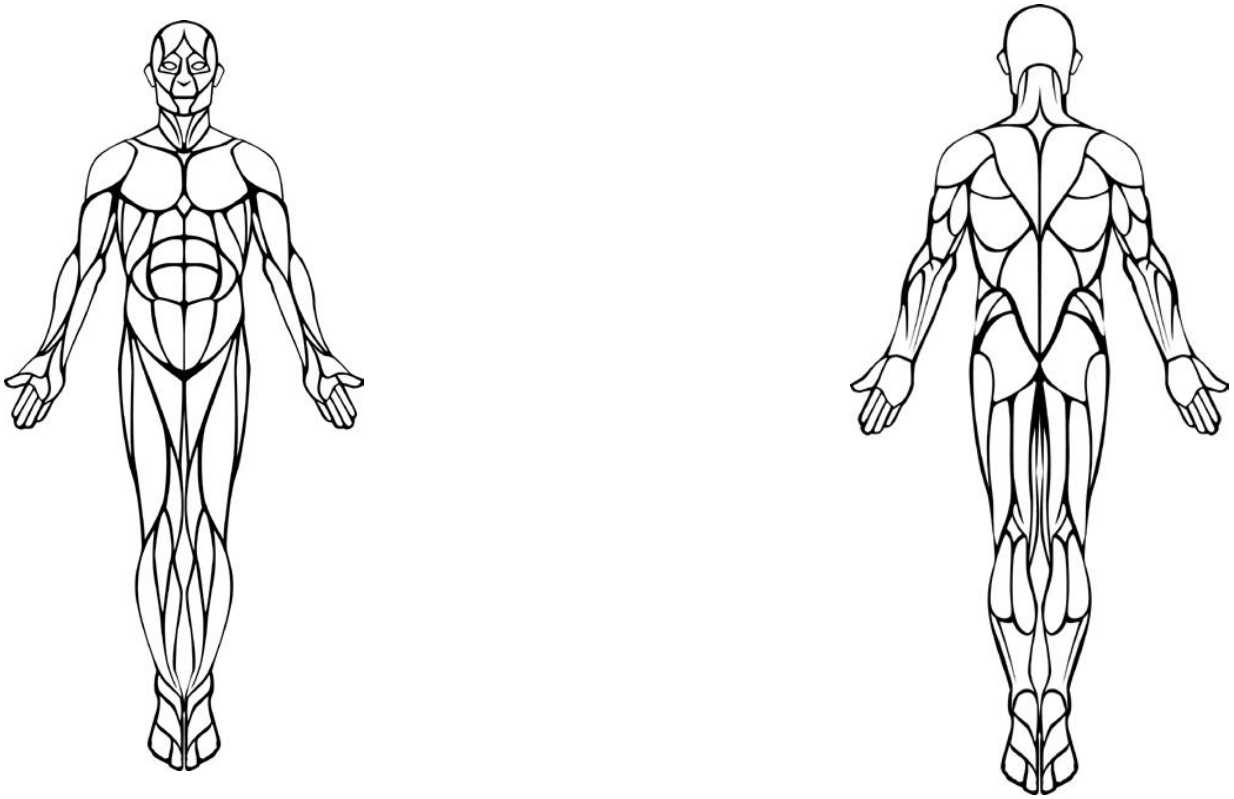
Contact Information

Name _____ Date of Birth _____
Address _____ City _____ State ___ Zip_____
Cell Phone Number _____
Provider for Text Reminders (example: Verizon or Sprint)_____
Email for Specials_____
Occupation _____
Emergency Contact _____
Relationship _____ Phone _____
How did you hear about us? _____

Your Session

What are you looking primarily for in your massage today?
Full Body Experience_____ Precise Therapeutic Attention_____ Both _____

Please mark with an "X" on the diagram below to indicate areas of tension or discomfort



Would you like these areas worked on? Please check yes or no.

Scalp Yes___ No___
Face Yes___ No___
Glutes Yes___ No___
Feet Yes___ No___
Pectoral Yes___ No___

Medical History

Do you exercise regularly? Yes No

Type: _____

Are you currently under the care of a physician who is not your primary? Yes___ No___

Name, phone number, and what for _____

_____

Are you using any medications or other substances? If yes, please list below:

_____

Please list any surgeries, accidents, or major illnesses

_____

Please review the following list and check those conditions that have affected your health either recently or in the past:

___ Arthritis
___ Allergies to _____
___ Diverticulitis
___ Asthma
___ Headaches
___ Diabetes
___ Heart Condition
___ Blood Clots
___ Hepatitis
___ Back Problems/Scoliosis
___ Insomnia
___ Broken/Dislocated bones
___ Muscle Strain/Sprain
___ Bruise Easily
___ Current Pregnancy: _____Weeks
Is your pregnancy considered "at risk" YES___ NO___

___ Cancer (Please list type below)
___ Seizures
___ Chemical Dependency
___ Skin conditions/Rash
___ Chronic Fatigue
___ Surgery
___ Chronic Pain
___ Tendonitis/Bursitis
___ Constipation/Diarrhea
___ TMJ Disorder
___ Depression, Panic Disorder, or other Psych Conditions
___ Varicose Veins
___ Vertigo
___ Whiplash

Additional information not listed above:

_____

Do you have any communicable diseases? _____

Consent for Care

Please read the following and sign below:

1. I understand that although massage therapy can be very therapeutic, it is NOT a substitute for medical examination, diagnosis and treatment.
2. I acknowledge that massage should not be done under certain medical conditions and I affirm that I have answered all questions pertaining to medical conditions truthfully. I will inform my practitioner of any changes in my health status, and all important communication from other care practitioners.
3. I understand that this is a therapeutic massage and any sexual remarks or advances will terminate the session, and I will be liable for payment of the scheduled treatment.

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.

Client Signature _____ Date _____

Practitioner Signature _____ Date_____