Massage Client Intake Form
(PLEASE FILL OUT ALL AREAS COMPLETELY)

PLEASE PRINT LEGIBLY

Name _____ Email _____
Address _____ City/State/Zip _____
Phone (Main) _____ (Cell) _____ Birthday _____/_____/_____
Referred by _____ Occupation _____
Emergency Contact _____ Phone _____

GENERAL and MEDICAL INFORMATION

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

1. Are you currently seeing a chiropractor, medical practitioner or psychotherapist on a regular basis? Y N
   a. If yes, please explain _____

2. Please check any condition listed below that applies to you. Please list the location of the condition where indicated:

☐ contagious skin condition	☐ phlebitis	
☐ open sores or wounds	☐ deep vein thrombosis/blood clots. Location_____	
☐ easy bruising	☐ joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis	
☐ recent accident or injury	☐ osteoporosis	
☐ recent surgery	☐ epilepsy	☐ high cholesterol
☐ artificial joint _____	☐ headaches/migraines	☐
☐ sprains/strains _____	☐ cancer (Yr/Location): _____	☐
☐ current fever	☐ diabetes	☐
☐ swollen glands	☐ decreased sensation _____	☐
☐ allergies/sensitivity	☐ back/neck problems	☐
☐ heart condition	☐ Fibromyalgia	☐
☐ high or low blood pressure	☐ TMJ / Jaw problems	☐
☐ circulatory disorder	☐ carpal tunnel syndrome	☐
☐ varicose veins	☐ tennis elbow - Right or Left	☐
☐ atherosclerosis	☐ pregnancy if yes, how many months?	

Please explain any condition that you have marked above. _____
_____
_____

3. Please list any medications, vitamins/herbs, over-the-counter medications/creams/drops you are currently using and for what reason even if you do not believe that they are important. Use back of page if needed.

_____
_____
_____

4. Please list surgical history even if you do not believe that it is important. Use back of page if needed. (Date/procedure).

_____
_____
_____

MASSAGE SPECIFIC QUESTIONS

1. Have you ever had a professional massage? Y N When / What type? _____
2. What results do you want from your massage session? □ pain relief □ relaxation □ other _____
3. Prioritize the top 3 areas of your body where you would like your massage to be focused.
   _____
4. List any areas to be avoided _____

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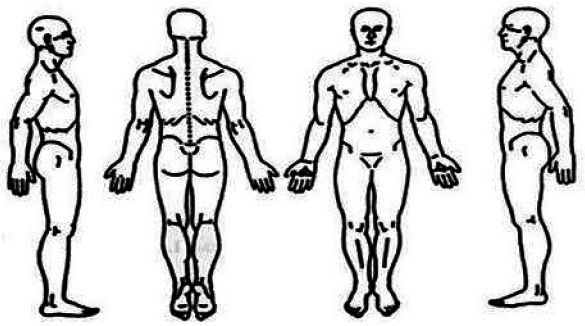

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PLEASE MARK WITH AN "X" ANY AREAS WHERE YOU ARE EXPERIENCING PAIN.

Draping will be used during the session – only the area being worked on will be uncovered.
Informed written consent must be provided by parent or legal guardian for any client under the age 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 massage 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 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 have 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. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

Cancellation Policy

You can reschedule or cancel your appointment free of charge, with a minimum 24-hour notice prior to your appointment. Less than 24 hours cancellation will result in charge of $25. "No shows" and less than 4-hour cancellations will be charged 100% of the reserved service amount.

Signature of client _____ Date _____