



MONADNOCK THERAPEUTIC BODYWORKS

Client Intake Form

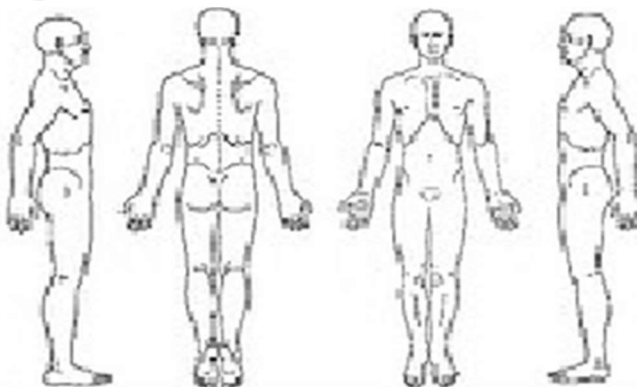
Name _____ email _____
Phone (Cell) _____ Referred by _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Occupation _____
Emergency Contact _____ Phone _____

The following information will be used to help plan safe and effective massage sessions.

- Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy? _____
- Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____

Please check any condition listed below that applies to you:

- | | |
|-----------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> contagious condition | <input type="checkbox"/> allergies |
| <input type="checkbox"/> stress | <input type="checkbox"/> sensitive skin/ easy bruising |
| <input type="checkbox"/> deep vein thrombosis/blood clots | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> heart condition |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> high or low blood pressure |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> pregnancy if yes, how many months? |
- Do you have any particular goals you are looking to accomplish with this massage session? Yes No
If yes, please explain _____



Please mark the areas of concern on the diagram

- Do you see a chiropractor? Yes No If yes, how often? _____
 - Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____
-

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. It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. 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 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 License Massage Therapy 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 _____

CONFIDENTIAL