Jennifer Collins Massage Intake Form

Name _____ Phone _____ DOB _____

Address _____ City/State/Zip _____

Occupation _____ Email _____

Emergency Contact _____ Relationship _____Phone _____

How did you hear about me? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along?_____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain_____

What makes it better?_____

_____

What makes it worse?_____

_____

Do you have any of the following?

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ Shoulder Injuries
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains
- ☐ Bruise Easily

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

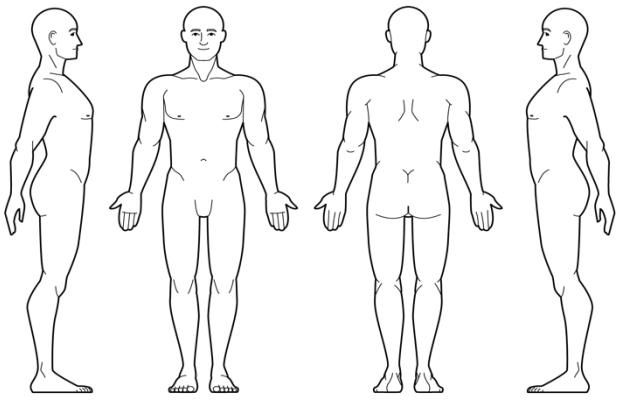
What are your goals for this treatment session?

_____

_____

_____

Please circle any areas of discomfort



By signing below, you agree to the following:

I have completed this form to the best of my ability and acknowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

General Liability Release Form

By signing below, you agree to the following:

1) I give my permission to receive massage therapy.

2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.

3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.

4) If I have any contraindications, I have clearance from my physician to receive massage therapy.

5) I understand the risks associated with massage therapy include, but are not limited to:

- Superficial bruising or skin irritation
- Short-term muscle soreness
- If cupping therapy is requested, cupping marks on skin may resemble bruises

I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

6) I understand that I or the massage therapist may terminate the session at any time.

7) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

8) I have reviewed a copy of the cancellation policy and understand the terms stated.

_____ _____

Signature Date