Restorative Massage Therapy

Gwen Stanton, CMT, NCTMB

Client Intake Form

Today's Date _____

Name_____ Occupation _____

Address_____ City_____ State_____ Zip _____

E-mail_____ Date of Birth _____

Cell Phone_____ Home Phone_____ Work _____

Emergency Contact_____ Phone _____

To ensure a comfortable massage session, I encourage you to ask me any questions that you may have. Please answer the questions below to the best of your knowledge.

Have you ever experienced a professional massage before? ☐ Yes ☐ No
If yes, how recent was your last massage? _____ If yes, how often do you receive massage? _____
If yes, what type of massage if known: ☐ Swedish ☐ Deep Tissue ☐ Shiatsu ☐ Reiki ☐ Other _____

What are your massage goals? _____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Do you have any allergies? ☐ Yes ☐ No
If yes, please explain_____

Please rate your average stress level 1 – 10 (10 Highest) _____ Rate your stress level today _____
How do you think stress has affected your health? ☐ Muscle tension ☐ Anxiety ☐ Insomnia ☐ Other _____

Do you exercise regularly or participate in sports? ☐ Yes ☐ No
If yes, please describe activity and frequency: _____

Do you drink WATER? ☐ Yes ☐ No
If yes, how much do you drink a day? _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? ☐ Yes ☐ No
If yes, please explain: _____

Do you have any of the following today? ☐ Sunburn ☐ Headache ☐ Open Cuts/Bruises ☐ Irritated Skin ☐ Cold/Flu ☐ Pregnant (Due Date _____)

Have you ever been in a car accident? ☐ Yes ☐ No If yes, when_____ Did you incur injuries? ☐ Yes ☐ No
If yes, please describe: _____

Do you still experience pain or discomfort from the injuries? ☐ Yes ☐ No

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Client Intake Form (Continued)

Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe: _____

Are you currently under a doctor's care? ☐ Yes ☐ No
If yes, please explain: _____

Do you see a chiropractor? ☐ Yes ☐ No
If yes, how often? _____

Are you taking any medication? ☐ Yes ☐ No
If yes, please list: _____

Please check any condition listed below that applies to you:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Varicose Veins
- ☐ Spider Veins
- ☐ Arthritis
- ☐ Recent fracture
- ☐ Recent surgery
- ☐ Deep vein thrombosis/blood clots
- ☐ Sinusitis
- ☐ Cancer
- ☐ Phlebitis
- ☐ Osteoporosis
- ☐ Diabetes Type _____
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ Carpal tunnel syndrome
- ☐ Tennis elbow
- ☐ Headaches/migraines
- ☐ Fatigue
- ☐ Blood clots
- ☐ Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
- ☐ Epilepsy
- ☐ Bruise easily

Please explain any condition that you have marked above_____
_____
_____

Is there anything else about your health history that you think would be useful for me to know to plan a safe and effective massage session for you? _____
_____

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 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 or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental illness, and that nothing said in the course of the session given should be construed as such. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental conditions and 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.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

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Cancellation and No-Show Policy

It is my intention to provide you with massage therapy reflective of my high level of expertise, presence, and caring. I take time to learn your needs, review any questions, and prepare for your appointments. I take extra time preparing for your aromatherapy and pregnancy massage sessions by selecting the necessary tools and essential oils I am guided to use for you on that day. Whenever you cancel at the last minute or not show for an appointment, it is time that would have benefitedsomeone else and represents missed business opportunities for me.

Rescheduling or Cancellations:
24 hours advance notice is requested. If you need to cancel or change an appointment, you must CALL, TEXT or EMAIL me at (908) 797-2745 or gwen@restorativemassagetherapy.net.

On occasion, I understand that unanticipated events happen in everyone's lives that do not allow you to give this amount of notice.

No Show:
If you do not show for your appointment and you do not contact me prior to your appointment time. You will be charged the full amount of your appointment. This amount must be paid prior to your next scheduled appointment. Thank you for understanding that my time is valuable and your massage is too.

Arriving Late:
Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, I will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session. Please plan accordingly and be on time or early.

I look forward to being a part of your wellness care and intend to always provide you with my best in massage therapy. Thank you for your commitment to yourself.

Signature _____ Date _____

AMTA Professional Member