The House of Hamsa

"Living More Mindfully Through Wellness"

Name _____ DOB_____Date _____

Mailing Address _____

City/State/Zip _____Phone _____

Email _____ Occupation _____

Emergency Contact _____ Relationship _____

Phone _____ Primary Care Physician _____

How did you hear about The House of Hamsa? _____

Are you currently or have you previously been under a doctors care for any of the following conditions:

☐ Headaches/Migraines	☐ Fibromyalgia
☐ Arthritis (Osteo/Rheumatoid)	☐ Heart Attack/Stroke
☐ Diabetes (Type 1, Type 2)	☐ Epilepsy/Seisures
☐ Anemia/Blood Disorders	☐ Numbness
☐ Anxiety/Depression	☐ Varicose Veins
☐ Joint Replacement(s)	☐ Osteoporosis
☐ High/Low Blood Pressure	☐ TMJ/Clenching
☐ Neuropathy	☐ DVT/Blood Clots
☐Kidney Dysfunction	☐Sprains, Strains, Concussions

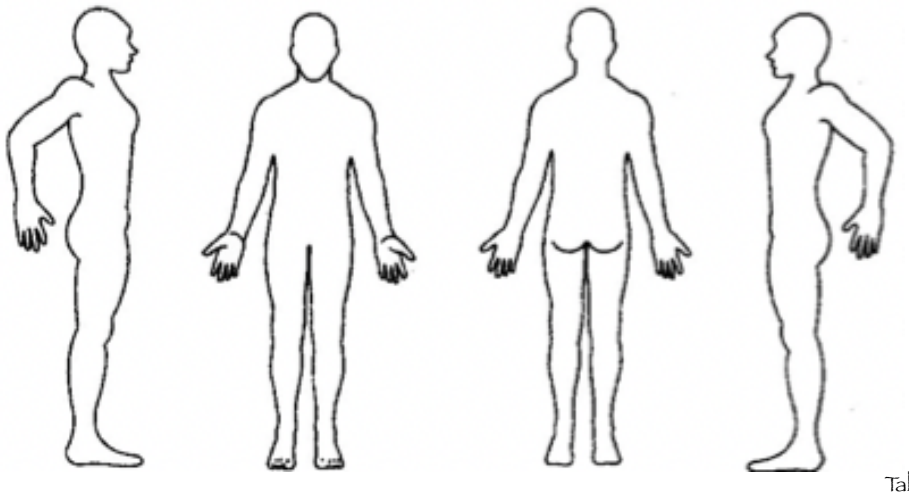
Are you currently taking any medications, prescription or over-the-counter? ☐ yes ☐ no

Please list name/use:_____

Are you currently pregnant? ☐ yes ☐ no If so, how many weeks? _____

Any high risk factors? ☐ yes ☐ no Please explain _____

Please circle any areas of discomfort:



Would you consider any of these areas chronic pain? ☐ yes ☐ no Explain: _____
Has your range of motion been impacted? ☐ yes ☐ no Explain: _____
Any recent orthopedic injuries, physical therapy or surgeries? ☐ yes ☐ no Explain: _____

Please list anything else about your current health or history your massage therapist should know before treatment: _____

Have you had a professional massage before? ☐ yes ☐ no
If so, when was your last massage? _____
What is your preferred amount pressure? ☐ Light ☐ Medium ☐ Deep
Do you have any specific goals for this session? _____

What type of massage are you seeking?
☐Swedish ☐ Deep Tissue ☐ Trigger Point ☐ Myofascial Release ☐ Prenatal/Pregnancy
☐ Raindrop Technique ☐ Aromatherapy ☐ PNF/Stretching ☐ Other _____

Do you have any allergies or skin sensitivities? ☐ yes ☐ no Explain: _____

If there are any areas you are not comfortable receiving massage (face, feet, abdomen, gluteals)?
Please indicate here: _____

By signing below, I agree to the following;

I have completed this form to the best of my knowledge and ability. Should any changes to the information provided arise, I assume full responsibility of communicating this with my therapist. I understand information collected during this intake may have a direct impact on the type of session I receive and that some conditions may even be contraindicated for massage. If I experience any pain or discomfort during my session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy does not take the place of a medical examination, diagnosis, or treatment and I should see a physician or qualified specialist as needed.

Client Signature _____ Date _____

Therapist Signature _____ Date _____