

Holistic Living Solutions Massage Intake Form – CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email : _____

Occupation: _____

How did you find Holistic Living Solutions? _____

Have you ever received massage therapy? _____ Yes _____ No

Type of massage experienced (Swedish, shiatsu, deep tissue, etc) _____

Are you currently taking any medications? _____ Yes _____ No

If Yes, please list name and reason for medications

Are you currently seeing a healthcare professional? _____ Yes _____ No

If yes, please list names and reason/treatment

Please review this list and check those conditions that have affected your health either recently or in the past.

- | | | |
|---|---|---------------------------------|
| ____ Arthritis | ____ Depression, panic disorder or other psych. condition | |
| ____ Diabetes | ____ High Blood Pressure | ____ Insomnia |
| ____ Blood Clots | ____ Diverticulitis | ____ Muscle Strain/Sprain |
| ____ Broken/Dislocated Bones | ____ Headaches | ____ Pregnancy |
| ____ Bruise Easily | ____ Heart Condition | ____ Scoliosis |
| ____ Cancer | ____ Back Problems | ____ Seizures |
| ____ Chronic Pain | ____ Stroke | ____ Whiplash |
| ____ Constipation/Diarrhea | ____ Surgery | ____ Chemical Dependency |
| ____ Skin Conditions | ____ TMJ Disorder | ____ Hepatitis (A, B, C, other) |
| ____ Auto-immune Condition (AIDS, Fibromyalgia, chronic fatigue, lupus, etc...) | | |

If any of the listed conditions need to be detailed or if there is anything else to share, please do so:

Do you have any of the following TODAY:

____ Skin Rash ____ Cold/Flu ____ Open Cuts ____ Severe Pain
____ Injuries/Bruises ____ Anything contagious

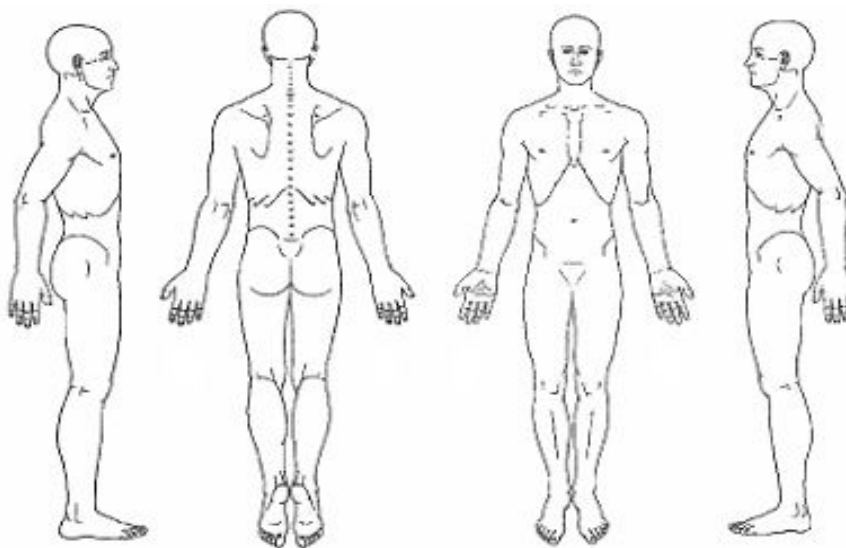
Do you have any allergies to:

____ Medications ____ Food (nuts, etc.) ____ Environmental allergens (dust, pollen, fragrances)
____ Skin Care Products

If any of the above are checked, please give details: _____

Are you wearing: ____ Contact Lenses ____ Hearing Aid ____ Hairpiece

Please indicate with an (X) the areas, if any, in which you are feeling discomfort:



What are your goals/expectations for this therapy session? _____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: ~ The need to move or change positions ~ Sighing, yawning, change in breathing ~ Falling asleep ~ Stomach gurgling ~ Emotional feelings and/or expression ~ Movement of intestinal gas ~ Energy shifts ~ Memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date: _____