

Integrative Healing Arts

Medical and Wellness Massage

www.iha-holistic.us

Brenda Dickenson, LMBT

(NY# 28956 NC# 16935)

Massage Therapy Intake Form

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone (home/cell/work): _____

Pronoun: _____ (example: she/her, he/him, they/them) Email Address: _____

Occupation: _____ Referred by: _____

Emergency Contact: _____ Phone: _____

General and Medical Information:

Do you suffer from chronic pain? yes no If yes, please explain _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? yes no If yes, please list: _____

Please indicate any of the following that apply to you.

- | | | |
|--|--|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Anxiety / Depression |
| <input type="checkbox"/> Osteoporosis / Bone loss | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Back / neck problems | <input type="checkbox"/> Blood Clots / Clotting issues | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Broken Bone (in last 2 years) | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Circulatory disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Allergies / Sensitivity | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Current Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sprains or Strains | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Recent surgery (in last 2 years) | <input type="checkbox"/> Recent accident of injury | <input type="checkbox"/> Open Sores / Wounds |
| <input type="checkbox"/> Pregnancy - if so, how far along? _____ | | <input type="checkbox"/> Contagious Skin Condition |

Explain any conditions you have marked above: _____

List any medications or supplements that you are currently taking: _____

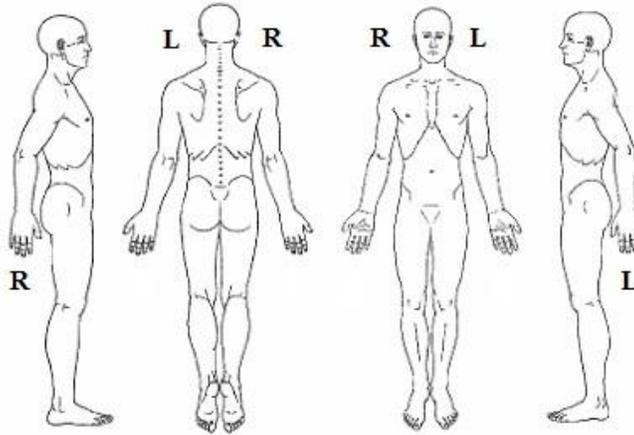
Please any known list allergies: _____

Have you ever had a professional massage? Yes No If so, pressure preferred: Light Medium Firm

Are you sensitive to touch or pressure in any area? Yes No If so, where? _____

Reasons for seeking massage therapy: _____

Please identify the areas of concern on the chart below:



Release

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms that may make massage therapy contraindicated please seek a referral from your medical doctor.

By signing this, I agree that I have answered all questions honestly, to the best of my knowledge and have stated all my known medical conditions. I will inform the therapist of any changes in my medical condition and/or medications and understand that there shall be no liability on the therapist's part should I forget to do so. I understand that massage therapy is a therapeutic measure used to reduce stress, relieve muscular tension, and for pain elimination. If I experience any pain/discomfort during this or any other session I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my comfort level.

This is therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for full payment of the scheduled treatment.

I understand that a massage should not be construed as a substitute for medical examination, diagnosis or treatment by a physician. I further 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 sessions should be construed as such. I understand that it is my responsibility to consult a physician for any ailments I may have.

I understand that if I use a coupon during my visit, it is not valid with any other coupons or promotions. I understand that all payments are due at the time of service.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

Print Name: _____

Signature: _____

Date: _____

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217 Union Street, Cary, NC 27511
(315) 415-3791

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Cancellation Policy

I understand that unanticipated events happen occasionally in everyone's life. When you book an appointment that time is reserved especially for you. Missed appointments are costly in lost time and revenue, and it prevents me from providing services to other clients. In my desire to be effective and fair to all clients, the following policies are put in place:

24 hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours advance notice you will be charged 50% of your scheduled appointment charge. This amount will be billed to you and must be paid prior to your next scheduled appointment.

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a no-show and will be charged for their missed appointment. The full amount for the session missed will be billed to you and must be paid prior to your next scheduled appointment.

Late Arrivals

If you arrive late to your scheduled appointment, your session may be shortened in order to accommodate others whose appointments follow yours. Your therapist will 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" scheduled session.**

Payment

Full payment is expected before or after treatment at the time of service. All clients, whether they have received treatment or booked an appointment are bound by this policy without any prejudice or exemption.

Returned Checks

There is a fee of \$25.00 for a returned check.

By signing this I am stating that I fully agree with and understand the above policy.

Name: _____ Date: _____