Little Hands Therapeutic Massage

Massage Intake Form

Personal Information

Name________________________ DOB______________ Sex_____________

Address____

City/State/Zip____

Phone_________________________ Email__________________________________

Occupation____

Emergency contact____

Referred By____

The following information will be used to help plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

1. Have you ever had a professional massage before? Yes No
2. Do you have difficulty laying on your front, back or side? Yes No
3. Do you have any allergies to lotions., oils or ointments? Yes No
4. Are you wearing contact lenses, dentures or a hearing aid? Yes No
5. Do you have any repetitive movement in your work, sports or hobby? Yes No
6. Are you pregnant? Yes No
   If yes, how many months______________
7. Are you under medical supervision? Yes No
8. Do you see a chiropractor? Yes No
9. Are you currently taking any medications? Yes No
   If yes, please list ____

____

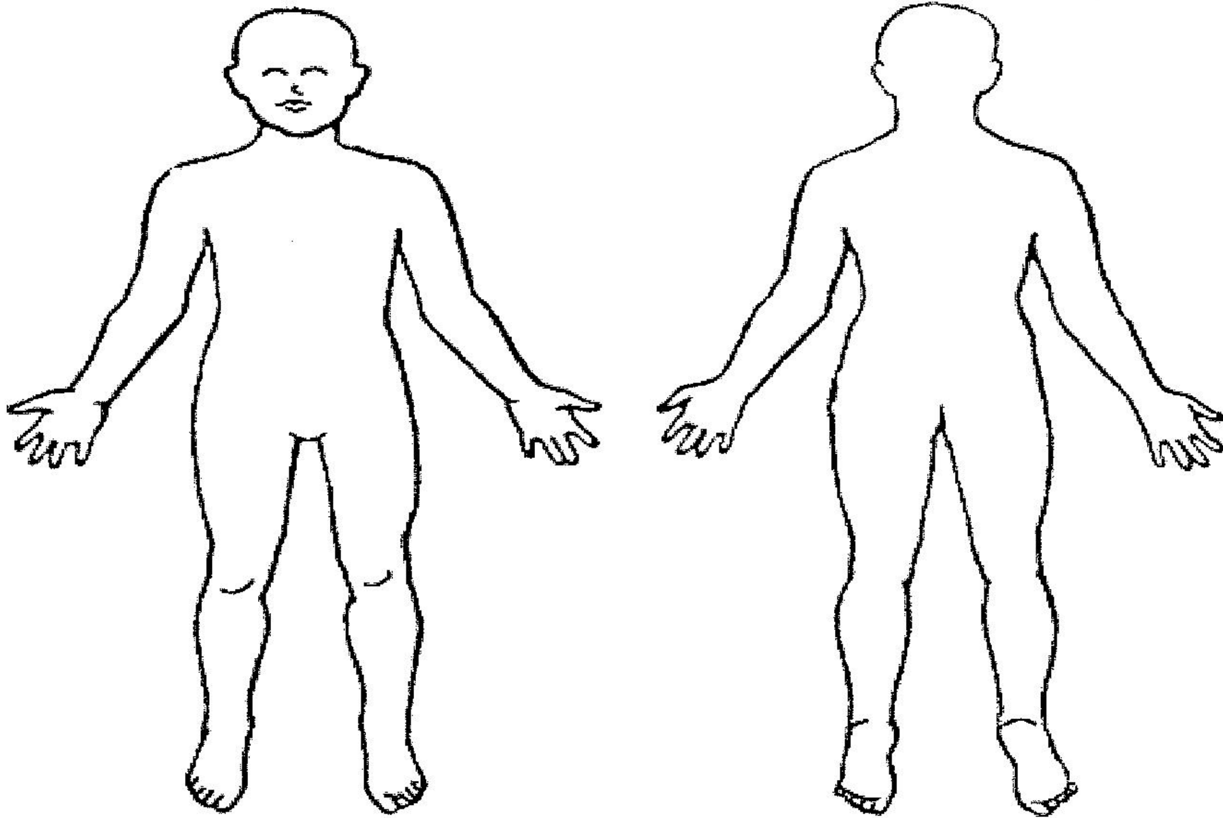
10. Please check any condition listed below that applies you :

( ) Contagious skin condition
( ) Open sores or wounds
( ) Easy bruising
( ) Recent accident or injury
( ) Recent fracture
( ) Recent surgery
( ) Artificial joint
( ) Sprains/ strains
( ) Current Fever
( ) Swollen glands
( ) Allergies/ Sensitivity
( ) Heart condition
( ) High or low blood pressure
( ) Circulatory disorder
( ) Varicose Veins
( ) Atherosclerosis
( ) Phlebitis
( ) Deep vein thrombosis/ blood clots
( ) Joint disorder
( ) Osteoporosis
( ) Epilepsy
( ) Headaches/ Migraines
( ) Cancer
( ) Diabetes
( ) Decreased Sensation
( ) Back/ Neck problems
( ) Fibromyalgia
( ) TMJ
( ) Carpal tunnel syndrome
( ) Tennis elbow

Please explain any condition that you have marked above________________________

____

Please circle any specific areas you would like to concentrate on during the session :



Informed Consent

I (print name) ____________________ understand that Nicole Banks is an educated and licensed Massage Therapist. 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 Nicole so that the pressure and/or stokes can my adjusted. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment. I should see a physician , chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that Nicole is 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 session should be construed as such. I affirm that I have stated all my known medical conditions, and answered all questions honestly to the best of my knowledge. I Understand that all massage treatments, information and records will be safe guarded and remain confidential. I understand that I may refuse, modify or terminate treatment at any time regardless of prior given consent and that Nicole may refuse to treat any client or part of their body with just and reasonable cause. I agree to keep Nicole updated as to any changes in my medical profile and understand that Nicole will not be liable should I fail to do so.

Clients Signature ____

Date________________________