



**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.

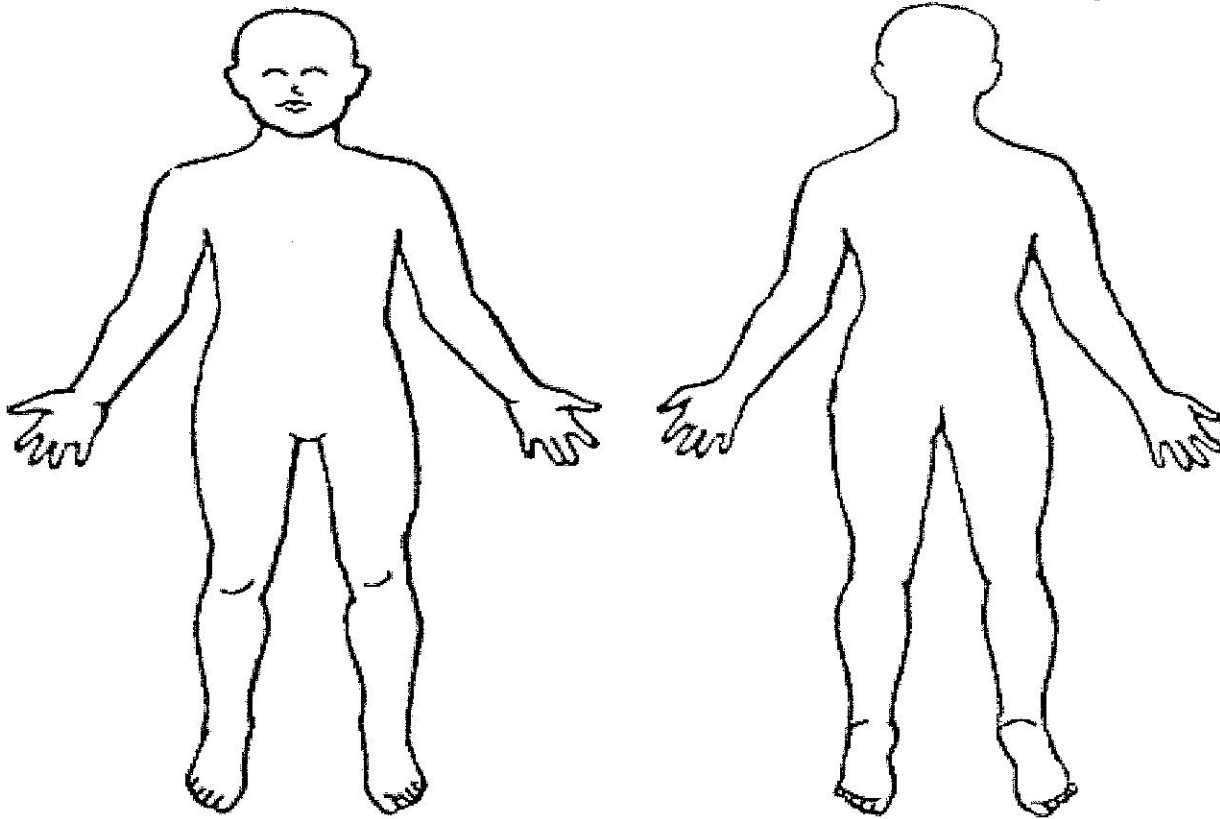
- | | | |
|---|-----|----|
| 1. Have you ever had a professional massage before? | Yes | No |
| 2. Do you have difficulty laying on your front, back or side? | Yes | No |
| 3. Do you have any allergies to lotions., oils or ointments? | Yes | No |
| 4. Are you wearing contact lenses, dentures or a hearing 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 | () Phlebitis |
| () Open sores or wounds | () Deep vein thrombosis/ blood clots |
| () Easy bruising | () Joint disorder |
| () Recent accident or injury | () Osteoporosis |
| () Recent fracture | () Epilepsy |
| () Recent surgery | () Headaches/ Migraines |
| () Artificial joint | () Cancer |
| () Sprains/ strains | () Diabetes |
| () Current Fever | () Decreased Sensation |
| () Swollen glands | () Back/ Neck problems |
| () Allergies/ Sensitivity | () Fibromyalgia |
| () Heart condition | () TMJ |
| () High or low blood pressure | () Carpal tunnel syndrome |
| () Circulatory disorder | () Tennis elbow |
| () Varicose Veins | |
| () Atherosclerosis | |

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 strokes can be 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 _____