Client Intake Form

Name: _____Date : _____
Address: _____
City, State, Zip:_____
Cell phone:_____ Email:_____
Occupation:_____ Date of birth:_____
Referred By:_____

Massage Preferences:

Have you had a professional massage before? _ Yes _ No
If yes, what types of massage have you had (Swedish, shiatsu, deep tissue, etc.)?:
_____
How long have you been receiving massage therapy?:_____
What are your goals for treatment?:
_____
_____

Do you have any of the following conditions? Please check all that apply.

_ Bone or joint disease	_ Tendonitis/Bursitis	_ Arthritis/Gout)
_ Spinal Problems	_ Migraines/Headaches	_ Osteoporosis
_ Heart Condition	_ Phlebitis/Varicose Veins	_ Lupus
_ Blood Clots	_ High/Low Blood Pressure	_ Lymphedema
_ Thrombosis/Embolism	_ Jaw Pain (TMJ)	_ Sinus Problems
_ Emphysema	_ Allergies	_ Breathing Difficulty/Asthma
_ Shingles	_ Numbness/Tingling	_ Pinched Nerve
_ Chronic Pain	_ Paralysis	_ Multiple Sclerosis
_ Rashes	_ Cosmetic Surgery	_ Athlete's Foot
_Herpes/Cold Sores	_ Parkinson's Disease	_ Irritable Bowel Syndrome
_Colitis	_ Crohn's Disease	_ Ulcers
_ Headaches/Migraines	_Vertigo/Dizziness	_ Ringing in Ears
_ Hearing Loss	_ Vision Problems	_Vision Loss
_ Anxiety/Stress/PTSD	_ Depression	_ Bladder/Kidney problems
_ Diabetes	_ Contact Lenses	_ Dentures
_ Hearing Aids	_Cancer/Tumors	_ Lyme Disease
_Pregnant, weeks_____	_ Prostate issues	_ Ovarian/Menstrual Problem

Any other medical condition(s) not listed: _____
_____
_____
Please explain any of the conditions that you have marked above:
_____
_____
_____

Policies:

Client services and chart information are confidential. Written authorization is required from you to release any information.

- Your scheduled session is set aside for you. If you are unable to make your appointment please let us know as soon as possible.
- Please reschedule your session if you are feeling sick.
- I understand that my therapeutic massage therapist or I may end the session at any time for any reason.
- Inappropriate behavior will not be tolerated and may be prosecuted to the full extent of the law.

Client Agreement:

I understand that therapeutic massage therapists do not diagnose illness, disease, any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals.

I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for that service.

It is my choice to receive therapeutic massage as a form of therapy.

I understand that treatment given is designed to address the care and prevention of myofascial pain and dysfunction.

I also understand and that at any time I feel pain or discomfort during the session, I will immediately inform my therapeutic massage therapist so they adjust.

I have stated my pertinent medical conditions, and will update the massage therapist of any changes in my health status.

I understand that my failure to do so may post a threat to my health and/physical well being and I hold harmless Right Balance Body and Skincare and my therapeutic massage therapist from any liability whatsoever arising from failure on my part.

By my signature below, I agree to the massage policy and client agreement above.

Printed Name :_____Date:_____

Signature: _____