

Massage Transforms You

NEW CLIENT INTAKE FORM

Name _____ Date _____
Address _____
Phone _____ Date of Birth _____ Gender _____
Email _____ Occupation _____
Emergency Contact _____ Phone _____

How did you hear about us? _____

Have you received massage therapy or bodywork before? Yes No

Are you on any medication? Yes No If yes, which ones _____

Do you exercise? Yes No If yes, how many times per week? _____ How many hours? _____

What exercise / activities do you partake in? _____

****Please mark any of the following conditions you may currently have.**

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Alcohol within 24hrs | <input type="checkbox"/> Recent surgery |
| <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Numbness | <input type="checkbox"/> Open wounds |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Kidney Dysfunction | <input type="checkbox"/> Bruises | <input type="checkbox"/> Blood clot |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fever within 24hrs |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Wear contacts |
| <input type="checkbox"/> Recent Cold / Flu | <input type="checkbox"/> Acute pain | <input type="checkbox"/> Others, please specify: |
| <input type="checkbox"/> Sprain or Strain | <input type="checkbox"/> Chronic Pain | _____ |
-
-

Are you currently pregnant? Yes No If yes, how far along? _____

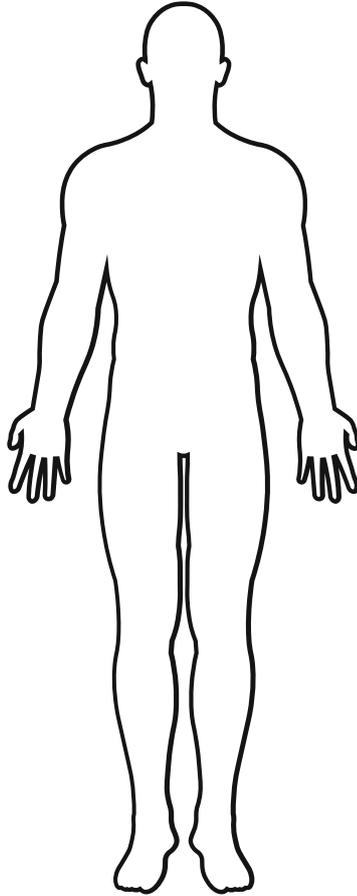
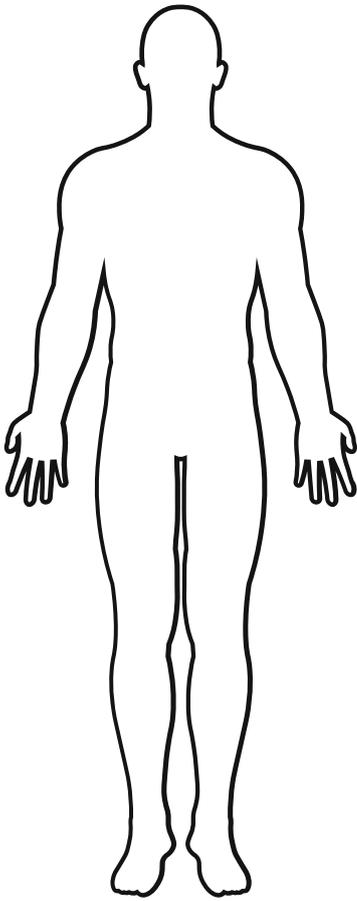
Any high risk factors? _____

Do you have any allergies or sensitivities? Yes No If yes, please explain: _____

Please circle areas of discomfort:

FRONT

BACK



What areas would you like to focus on today?

What type of massage are you seeking today?

- Swedish / Relaxation
Therapeutic / Deep Tissue

What pressure do you prefer?

- Light
Medium
Deep

Are there any areas you would NOT like massaged? (i.e. face, scalp, feet, etc.)

Yes No

If yes, please explain: _____

What are your goals for this treatment session? _____

I agree the above information provided is accurate and true to the best of my knowledge. I agree to inform the therapist if I experience any pain or discomfort during the session. I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perform spinal manipulations. I will inform the therapist of my current medical condition at the time of each visit and understand there is no liability on the therapist should I fail to do so. I DO understand if any inappropriate or sexual misconduct takes place, the session will be terminated and I will be charged the full session and asked to leave, without issue.

24hr cancellation policy ~ \$75 fee

Client Signature _____ Date _____

LMT Signature _____ Date _____