Client Intake Form - Therapeutic Massage

Blue Wolfe Vital Wellness
Vicente Wolfe LMT
MA101679 MM45125

Client Information

Name ______________________________ Email ______________________________

Phone (cell/day) ______________________________ DOB ______________ Age: __________

Address ______________________________ City/State/Zip ______________________________

Emergency Contact Name ______________________ Phone ______________ Relationship __________

Occupation ______________________________ Referred by: ______________________________

Health Information

Are you taking any medications? ☐ yes ☐ no If yes, please list: ______________________________

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no If yes, please list: ______________________________

Are you pregnant? ☐ yes ☐ no If yes, how many months: ______________ Due date: ______________

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☐ no

If yes, please describe: ______________________________

Areas of swelling	yes	no	Diabetes	yes	no	Osteoporosis	yes	no
Autoimmune disorder	yes	no	Fibromyalgia	yes	no	Phlebitis	yes	no
Back / neck problems	yes	no	Headaches	yes	no	Sciatica	yes	no
Bleeding disorders	yes	no	Heart condition	yes	no	Seizures	yes	no
Blood clots	yes	no	Hypertension	yes	no	Stroke	yes	no
Bruise easily	yes	no	Kidney disease	yes	no	Tendinitis	yes	no
Bursitis	yes	no	Multiple sclerosis	yes	no	TMJ disorder	yes	no
Cancer	yes	no	Neurological condition	yes	no	Varicose veins	yes	no
Contagious condition	yes	no	Neuropathy	yes	no	Vertigo / dizziness	yes	no
Decreased sensation	yes	no	Osteoarthritis	yes	no			

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? ______________________________

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? ______________________________

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: ______________

____

Please describe any other injuries or health conditions: ______________________________

____

Massage Information

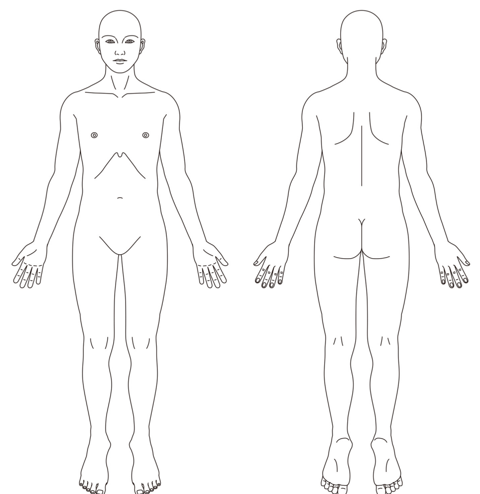
Have you had professional massage before? ☐ yes ☐ no How recently? ______________________________

Reason for seeking massage: ☐ Relaxation ☐ Specific problem

____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of discomfort



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature ______________________ Date __________

Therapist Signature ______________________ Date __________

Client Stretch Intake Form

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Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, are they blood thinners or for high blood pressure? ☐ yes ☐no

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? ____________________________________

Any high risk factors? ____________________________________

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain ____________________________________

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: ______________________________________

Are you in significant pain? How severe is the pain (using scale of 1 to 10 with 10 being the most severe - having to go to ER)

1 2 3 4 5 6 7 8 9 10

Please indicate any of the following that apply to you.

- ☐ Inflammation
- ☐ Cancer
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement (s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Headaches/Migraines
- ☐ Surgery
- ☐ Infection
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Blood Clots
- ☐ Numbness
- ☐ Loss of Mobility
- ☐ Sprains or Strains
- ☐ Dislocation/Fractures

Explain any conditions you have marked above:

____

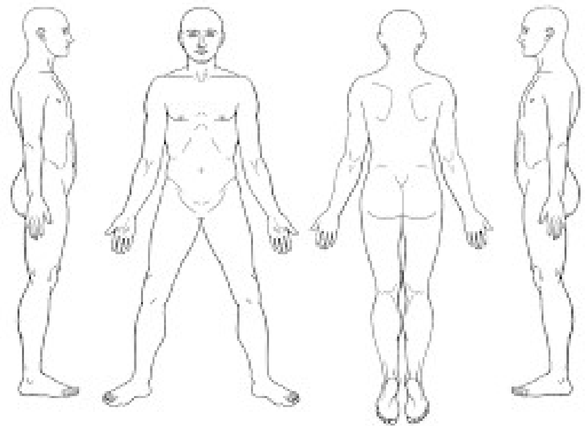
____

____

Stretch Information

Have you had a professional stretch before? ☐ yes ☐ no

Please circle any areas of discomfort



I understand that stretch therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation, assist in greater stretch gains of range of motion and energy flow. ☐ yes

If I experience pain/discomfort during the session, I will immediately inform my therapist so that pressure can be adjusted to my level of comfort. I will not hold my therapist liable should I choose to not say anything if I have pain/discomfort. ☐ yes

I understand that there is a 24-hour cancellation policy. If I am unable to cancel before that time I will be responsible of the costs associated with that session and may be required to pay prior to any additional sessions. If I arrive late to my appointment, only the allotted time remaining may be utilized and I'm responsible for the full payment. ☐ yes

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature ________________________ *Date* ____________

Therapist Signature ______________________ *Date* ____________

Cupping Therapy - Consent and Release Form

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MA101679 MM45125

About Cupping Therapy

Cupping is a therapeutic technique that comes from traditional Chinese medicine (TCM) and is believed to have numerous health benefits in addition to stimulating the flow of qi ("life force") within the body. This body treatment integrates well with massage therapy, and involves applying a localized negative pressure (suction) to the skin using glass, plastic or silicone cups at targeted areas of the body. The intent of this therapy is to stimulate the function of the circulatory and lymphatic systems. It may also help to release congested tissues and loosen adhesions at superficial tissues of the body.

Contraindications for Cupping Therapy

The following is a partial list of common conditions which are considered contraindications for cupping therapy:

- Blood clots
- Bleeding disorders
- Bruise easily
- Hemophilia
- Injured areas
- Infections
- Acute skin conditions
- Sunburn / rash
- Skin lesions
- Cancer
- Areas of herniation
- Hematomas
- Phlebitis / varicose veins
- Impaired sensation
- Edema / lymphedema
- Certain medications

Please Read and Initial Each Item Below

_______ Information about massage cupping in general, techniques, potential benefits, effects, risks, after-care recommendations, and possible alternative therapies have been explained to me and I understand this information.

_______ I understand that the vacuum formed by cupping may result in marks being left on my body.

_______ My therapist has informed me of the contraindications of cupping therapy, and I have provided my therapist with an accurate and complete medical history to rule out any contraindications to receiving this treatment.

_______ I agree to communicate to my therapist any physical discomfort experienced during the session.

_______ I have been given an opportunity to ask questions about cupping therapy and have had my questions answered to my satisfaction.

_______ I am not taking blood thinners, and I have no contraindications for cupping therapy.

_______ I release the massage therapist and business from all liability for any harm that may unintentionally result from this treatment.

I further understand that massage and cupping therapy is not a substitute for a medical examination or treatment, and that I should see a physician or other qualified health specialist for any mental or physical ailment of which I am aware. I understand that massage therapists do not diagnose illness or disease, and nothing said during the treatment should be construed as such. My consent is informed and voluntary and I understand that I may withdraw my consent at any time except for actions already taken.

By signing this form I agree with the statements above and give my consent to proceed with cupping therapy.

____

Client Name (Please Print)

__________/__________/__________

Date

____

Client Signature