Be Well Therapeutics LLC -Massage Therapy Intake Form

Name _____ DOB ____/____/____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Occupation _____ Referred By _____

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED. IF YOU HAVE A SPECIFIC MEDICAL CONDITION OR SPECIFIC SYMPTOMS OR ARE PREGNANT OR POST-PARTUM, MASSAGE/BODYWORK MAY BE CONTRAINDICATED. A REFERRAL FROM YOUR PRIMARY CARE PROVIDER MAY BE REQUIRED PRIOR TO SERVICES PROVIDED.

Have you ever experienced a professional massage? If so, how long ago?

Is there anywhere you are sensitive to touch or pressure?

Preferred massage pressure: Light Medium Firm

Do you bruise easily?

Women: Are you pregnant or trying to conceive? If so, how far along?

-If you answer yes to any of the following please explain-

Have you had any broken bones, recent injuries? _____

Have you had any surgeries or medical procedures? _____

Do you have any pain, tension, or soreness? _____

What are your massage goals? _____

-Please check the box if you have these symptoms-

- ☐ Stress
- ☐ Headache
- ☐ Migraines
- ☐ TMJD
- ☐ Diabetes
- ☐ Arthritis
- ☐ High blood pressure
- ☐ Cardiac/circulatory issues
- ☐ Back pain
- ☐ Numbness/stabbing pains
- ☐ PMS
- ☐ Endometriosis
- ☐ PCOS
- ☐ Contagious
- ☐ Joint swelling
- ☐ Varicose veins
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Allergies/sensitivities
- ☐ Infection
- ☐ Depression
- ☐ Anxiety
- ☐ Blood clots
- ☐ Congestion

-Please tell me a little bit about your lifestyle-

What kind of job do you work? It is stressful? _____

_____

Do you have a good sleep routine? Do you feel rested? _____

_____

Do you exercise? What kind and how often? _____

_____

Do you typically feel at ease? _____

_____

Is there anything else I should know? _____

_____

_____

I understand that the therapeutic massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session I will immediately inform the practitioner so that the pressure/strokes may be adjusted to my level of comfort.

I further understand that massage/bodywork should not be constructed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical element of which I am aware.

I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and personal goals for the outcome of massage therapy and understand that there shall be no liability on Be Well Therapeutics, LLC or the person Moire Kathryn Roller should I fail to do so.

I also understand that any illicit or sexually suggestive remarks and/or advances made by me WILL result in immediate termination of the session and I will be liable for full payment of the appointment.

I understand that canceling my appointment within 24 hours will result in a 50% cancellation fee and that no-shows will be charged 75% of the service fee.

Client Signature _____ Date _____

Therapist Signature _____ Date _____