Body By Barb

CLIENT INTAKE & HEALTH HISTORY FORM

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: ____________________

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

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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

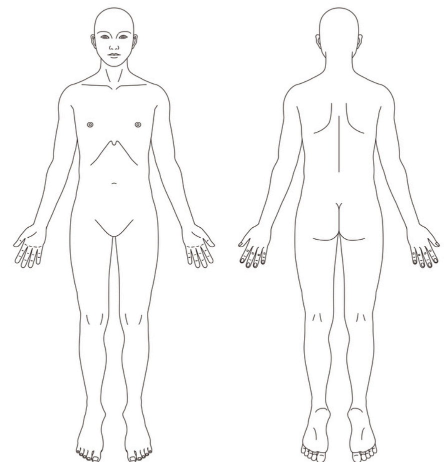
Have you had professional massage before? ☐ yes ☐ no How recently? ____________________

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 __________

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Consent for Treatment & Liability Waiver

By signing below, you agree to the following:

- I voluntarily request and consent to receiving massage therapy.
- I understand that the massage services provided are intended for general wellness, stress reduction, and relief of muscular tension only.
- To the best of my knowledge, I do not have any injuries or conditions that would prevent me from safely receiving massage therapy. I understand the importance of informing my massage therapist of all known medical conditions and medications, and I acknowledge that additional risks may be associated with my physical condition.
- If I experience any pain or discomfort during the session, I will immediately inform my therapist so that the pressure or technique may be adjusted to my comfort level. I will not hold the massage therapist responsible for any discomfort I experience during or after the session.
- I understand that the potential risks associated with massage therapy include, but are not limited to:
  - Minor superficial bruising
  - Short-term muscle soreness
  - Aggravation of an unknown or pre-existing injury
- I affirm that I do not have any contagious conditions that could pose a risk to my massage therapist or other clients.
- I understand that either I or the massage therapist may end the session at any time for any reason.
- I have had the opportunity to ask questions regarding massage therapy, and all of my questions have been answered to my satisfaction.

I acknowledge that I have been informed of the policies and procedures related to massage therapy and that I understand them. I understand that massage therapy is not a substitute for medical care, and that I should consult a physician or qualified health provider for any medical concerns I may have. I further understand that massage therapists do not diagnose or treat illness, injury, or disease, and that nothing said during the session should be interpreted as medical advice or diagnosis. My consent is informed and voluntary, and I understand that I may withdraw it at any time, except for services already provided.

By signing below, I give my consent to receive massage therapy as described above.

____
Client Name (Please Print)

______________________________________ ________/________/________
Client Signature Date

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