Massage Intake Form

Name:_____ Date of Birth:_____

Address:_____ City:_____ Zip:_____

Cell Phone #:_____ Home Ph #:_____

Email:_____ Employer/Occupation:_____

Would you like to receive a reminder for your appointment via: (Please Circle) Text or Call Yes / No

Are you over the age of 18? Yes / No **If not, a parental consent form must be presented prior to the massage*.

Emergency Contact (Name, Ph #, Relationship):_____

Primary Reason for the Appointment:_____

1. Have you ever had a professional massage before? Y / N If yes, how long ago?_____
2. Are you under the care of a medical practitioner? Y / N If yes, what kind?_____
3. Are you taking any medications? Y / N If Yes, please list here:_____
   _____
4. Pressure preference: Light Medium Deep

Before Treatment:

Have you had any injuries, surgeries, or other medical condition(s) in the past that may influence today's treatment? Y / N Please list:_____

Mark **X** for the following health conditions if they apply to you:

____ Blood Clotting Disorders

____Circulatory / Heart Disorder

____High Blood Pressure

____Muscle Cramping

____Cancer

____Skin Conditions

____Respiratory Problems

____Digestive Disorders

____Numbness / Tingling

____Herniated Discs

____Arthritis / Bursitis

____Jaw Pain

____ Back or Neck Discomfort / Injury

____Car Accident(s) Date:_____

____Varicose Veins

____Anemia

____Headaches

____Nausea

____Fainting/Dizziness

____Epilepsy

____TB/other communicable diseases

____Diabetes (Type1 / Type 2) Neuropathy

____Fractures or other bone trauma or Scoliosis

____Neurological Issues

Are you allergic to any essences or oils? Y / N

Are you wearing contact lenses? Y / N

Are you wearing dentures? Y / N

Have you had alcohol today? Y / N

Are you pregnant? Y / N If yes, how many months:_____

To make sure we say "Thank you!", please let us know if you were referred by anyone:

Name:_____

Consent for Treatment:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed 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 ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during 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 understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature:_____ Date:_____

Parent or Guardian Signature (in case of a minor):_____
Date:_____

NOTES (For Therapist use only):