Massage Intake Form – CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name _____ Date of Birth_____
Address_____
State_____ City_____ Zip_____ Home Phone _____
Work Phone _____Email_____ Occupation_____

Have you ever received massage therapy? ____Yes ____No

Are you currently taking any medications? ____Yes ____No

If yes, please list name and reason for medications _____
_____
Are you currently seeing a healthcare professional? ____Yes ____No
If yes, please list names and reason/treatment _____

_____

Please review this list and check those conditions that have affected your health within the past 2 years.

___arthritis
___diabetes
___blood clots
___broken/dislocated bones
___cancer
___chronic pain
___constipation/diarrhea
___auto-immune condition*
___hepatitis (A, B, C, other)
___skin conditions
___stroke
___surgery
___TMJ disorder
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

___depression, panic disorder, psych condition
___diverticulitis
___headaches
___heart conditions
___back problems
___high blood pressure
___insomnia
___muscle strain/sprain
___pregnancy (How far along are you?)___
___scoliosis
___seizures
___whiplash
___chemical dependency (alcohol, drugs)

If any of the above needs to be detailed or if there is anything else to share, please do so:

_____
_____

Do you have any of the following today:

___skin rash ___cold/flu ___open cuts ___severe pain
___anything contagious ___injuries/bruises

Do you have any allergies to?

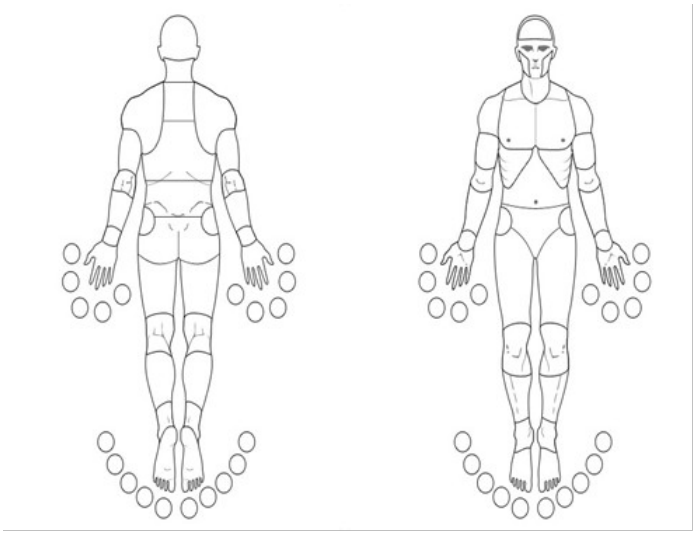
___medications ___foods (nuts, etc.) ___environmental allergens (dust, pollen, fragrances)
___reactions to skin care products

If any of the above are checked, please give details: _____

Please complete reverse side

Are you wearing: ___contact lenses ___hearing aid ___hairpiece

Please indicate with an (x), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? _____

_____

_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:

*need to move or change position * sighing, yawning, change in breathing, stomach gurgling * emotional feelings and/or expression movement of intestinal gas * energy shifts * falling asleep *

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis, and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
4. I will not hold my massage therapist responsible for any potential, but normal, results related to massage therapy.

(May include, but is not limited to, light bruising, soreness, headache, joint pain, etc.)

Cancellation/No Show Policy

A 24-hour cancellation notice is required for all sessions. Sessions not cancelled or rebooked prior to the 24-hour deadline will be charged a cancellation fee. This applies to no-show appointments as well. (Minimum fee $35)

Parent/Guardian Signature: _____ Date: _____
(If under 18 years old)

Patient Signature: _____ Date: _____