

# Therapeutic Massage



## Client Intake Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Marital status:  Single  Married

Children's Names and Ages: \_\_\_\_\_

Name of Spouse/Significant Other: \_\_\_\_\_

Preferred Appointment Day and Time: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Extension: \_\_\_\_\_

Permission to Consult with Primary Provider?  No  Yes \_\_\_\_\_ (please initial if yes)

In Case of Emergency, Please Notify:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

# Therapeutic Massage



## Health History

Medications: \_\_\_\_\_

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Please use back of form to explain all checked conditions

Client initials \_\_\_\_\_

### Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: \_\_\_\_\_

### Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: \_\_\_\_\_

### Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: \_\_\_\_\_

### Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: \_\_\_\_\_

### Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: \_\_\_\_\_

### Reproductive System

- Pregnancy:
  - Current
  - Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

### Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use \_\_\_\_\_
- Alcohol use \_\_\_\_\_
- Nicotine use \_\_\_\_\_
- Caffeine use \_\_\_\_\_
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list) \_\_\_\_\_
- Other congenital or acquired disabilities (please list) \_\_\_\_\_
- Surgeries \_\_\_\_\_
- Other: \_\_\_\_\_



## Massage Therapy Informed Consent

I, \_\_\_\_\_, (client) understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

## Policies:

### Cancellations:

Your business is valued and your cooperation is appreciated .We are making a commitment to you to guarantee your appointment time and refusing all other requests once you have made the appointment. A 24-hour cancellation notice is required for any scheduled appointments including gift certificate sessions. Missed or no-show appointments will result in your being charged the full amount of the session booked unless the appointment can be filled. Depending on our booking schedule, late appointments may not receive the full session time allotted for the treatment service booked: Full payment is required.. Emergency cancellations are determined by the Massage Therapist discretion.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_