

Get Massaged Client Intake Form

Name: _____ Sex: Male Female

Address: _____ City: _____ State: _____

Daytime Phone #: _____ Evening Phone #: _____

Date of Birth: _____ Occupation: _____

Marital status: Single Married Name of Spouse/Significant Other: _____

Primary Health Care Provider: _____

Telephone #: _____ Extension: _____

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

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____

Relationship: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? _ Yes _ No

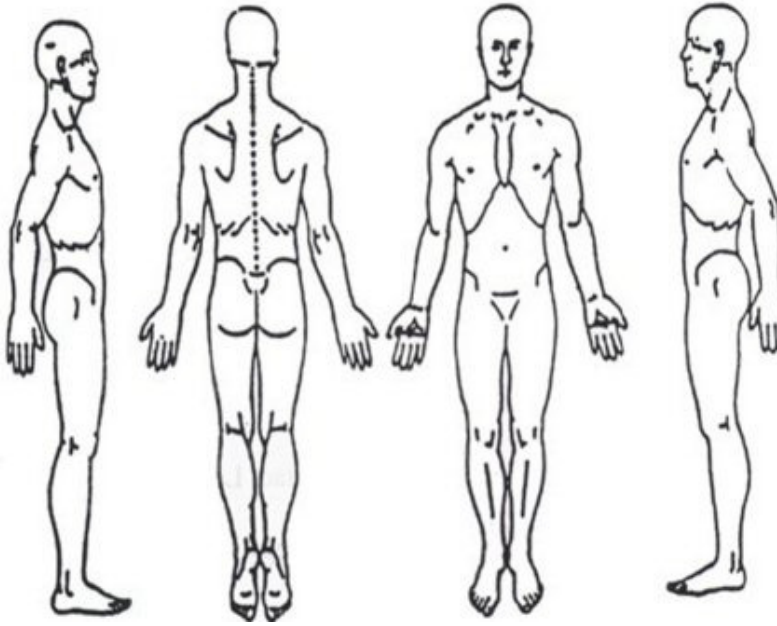
How recently? _____ What are your bodywork goals? _____

If you check 'Yes' to any of the following questions, please explain

<input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?
<input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two years?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?

<input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?
Please specify _____

<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area?
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below.
<input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any medications I should know about?
Comments



Please indicate on the body chart where you are experiencing pain and / or tension

Please Read the following and sign where indicated:

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 or 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 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 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.

If I must cancel a scheduled appointment I will do so no later than 24 hours before said appointment, if I don't give proper notice of cancellation I agree to pay the regular session fee in full.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____