



Confidential Client Intake Form



Last Name: _____ First Name: _____ D.O.B: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____ Cell: _____

Note: Email addresses are used for appointment reminders and business emails only. Email addresses will not be sold or distributed to outside agencies.

Occupation: _____ Emergency contact name & phone#: _____

Referred by: Google Yahoo Other : please provide referral source _____

Note: Personal referrers will be thanked and may receive a free massage as per referral policy .

Medical Information:

Please check all conditions that apply:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hypo or Hyperglycemia | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> TMJ Syndrome | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Skin Infections | <input type="checkbox"/> Contagious Conditions | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Contact Lens | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Muscle Sprain / Strain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Circulatory Conditions | |

Do you have other medical conditions not listed ? If so, please list:

Surgeries: (please list with dates): _____

Medication: (please list with purpose of medication): _____

Reason for visit: Stress Relief Pain Relief Both

Massage Information:

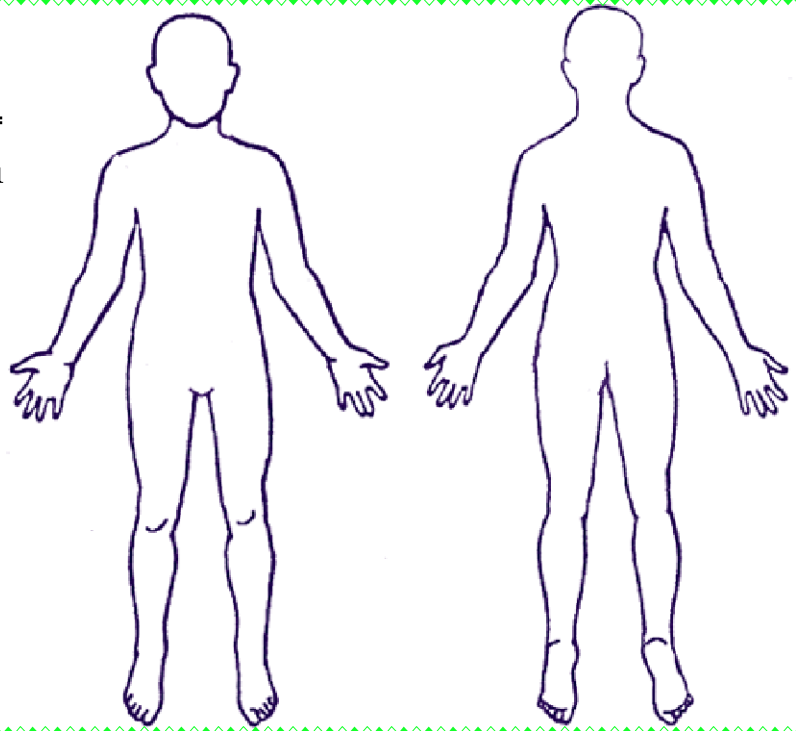
The type of massage techniques which may be used are: Swedish, Deep tissue, Trigger Point Therapy, Myofascial Release, Reflexology, Face Toning, Lymphatic drainage, Prenatal (if applicable), Hot Stone and Cold stone.

HAVE YOU HAD A MASSAGE BEFORE? Yes No

If Yes, please indicate preferable level of pressure: light medium deep

Please indicate on the following diagram:
Areas that have tightness or pain with an
"X"

Areas that you wish to be AVOIDED
wish to be massaged with an
"A"



Please read carefully and sign below.

- ◆ Draping (covering of the body with a sheet) will be used during the session and only the part of the body being worked on will be undraped during the massage.
- ◆ I (the client) understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment for any medical condition and that I should consult a physician or other qualified medical specialist for any mental or physical ailment.
- ◆ I understand that massage therapists are not qualified to perform any spinal or skeletal adjustments
- ◆ I have stated all medical conditions and answered all questions honestly.
- ◆ I agree to keep the therapist updated as to any changes in my medical profile and there should be no liability on the therapist's part should I fail to do so.
- ◆ I 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.
- ◆ I understand that if I am uncomfortable at any reason, I may ask the therapist to cease the massage and the therapist will do so.
- ◆ I understand that the therapist shall not engage in any breast massage for female clients and that sexual areas of the body will be always be avoided.
- ◆ I understand that I have marked additional areas to be avoided in the chart above.

I have read and agreed to the above.

Client Signature _____ Date ___/___/___

Massage Therapist: _____ Date ___/___/___