Client Intake Form

Please print clearly and complete all the responses to the best of your knowledge. (All information is strictly confidential)

Name____Birthdate____________________

Address____

Email____

Cell Phone____

Occupation____

Emergency Contact Name___________________________ Phone_______________________

Referred by____

Have you had a professional massage before? ___yes ___no

What type of pressure do you prefer? ___light ___firm ___ deep tissue

Would you like to be on email list? ___yes ___no

Are you a veteran?____

Have you been vaccinated for Covid-19? ___yes ___no

Are you currently under a physician's care? ___yes ___no

Are you currently experiencing cold or flu-like symptoms? ___yes ___no

Do you have a tendency to bruise easily? ___yes ___no

If answered yes, please
explain____

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Please check any of the following medical conditions/symptoms that you have experienced in the last year

- Heart Disease
- High Blood Pressure
- Hospitalization
- Hepatitis
- Carpel Tunnel Syndrome
- Sciatica
- Stroke
- Varicose Veins
- Surgery
- Psoriasis/Eczema
- Whiplash
- Asthma
- Diabetes
- Fibromyalgia
- Disc Problems
- Auto-immune Disease (HIV/Lupus)
- Insomnia
- Scoliosis
- Migraines/Headaches
- Pregnancy – how many weeks?
- Kidney or liver disease
- Allergies
- Arthritis

Are you a cancer survivor?____

Is there anything else you know of that might affect your massage?

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Please list any special requests or requirements for you massage

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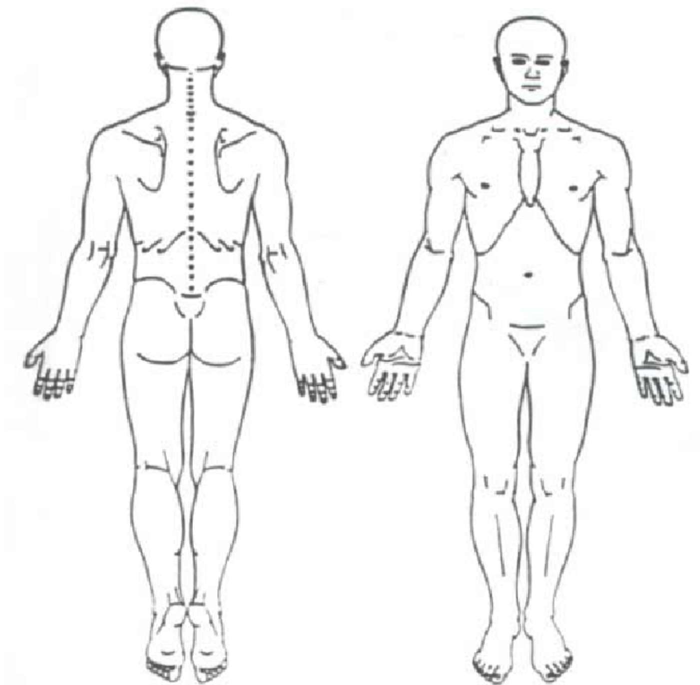
PLEASE INITIAL THE FOLLOWING STATEMENTS:

1. I am aware that draping will be used during the massage, including the genital area as well as breasts and gluteal cleavage. ___________
2. Breast massage will not be performed by this Massage therapist.___________
3. I understand that my feedback is an essential element in my treatment, therefore if at any time I should become uncomfortable during the massage, I may bring it to my therapist's attention and request the session end. _________

Please circle the areas you would like to concentrate on.



Please read the following statements, then sign at the bottom.

- I have read and fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist and update this form before receiving additional massages.
- The massage treatment given here is for the sole purpose of stress reduction, relief from muscle tension or spasm and to increase circulation and energy flow.
- The Massage Therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder.
- The Massage Therapist does not do spinal manipulations.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present and future relating to massage therapy and bodywork.

_____________________________________ _______________________

Client Signature Date

____

Massage Therapist Signature

TO BE COMPLETED BY MASSAGE THERAPIST

The following type of massage techniques will be used in the session

Swedish _______

Deep Tissue _______

Reflexology ________

Hot Stone________

Vibrational Sound________

Pregnancy________

Notes____
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