MASSAGE INTAKE FORM

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

Date _____ Client Name _____ DOB _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Cell Phone_____ Work Phone_____

Primary Email Address_____

Occupation _____ Referred By _____

Emergency Contact _____ Phone_____

Have you ever experienced a professional massage or bodywork session? ____No ____Yes How recently?_____

What is your desired pressure? ___ Light ___ Medium ___ Deep Are you wearing: ___ contact lenses ___ hearing aid ___hairpiece

Are you sensitive to touch in any area? Please list: _____

What is your purpose for seeking massage therapy / bodywork? ☐ General Relaxation ☐ Stress Management ☐ Injury Prevention ☐ Injury Recovery ☐ Pain Management ☐ Other _____

Please list any injuries / accidents / surgeries you've had in the past 5 years: _____

_____

Place a check mark next to any of the following that you have now or have had in the past:

Auto-Immune Conditions
_____ Fibromyalgia
_____ Chronic Fatigue
_____ Myofascial Pain Syndrome
_____ Lupus
_____ AIDS / HIV

Respiratory
_____ Breathing difficulty / Asthma
_____ Emphysema
_____ Sinus problems
_____ Chronic or frequent cough
_____ Allergies (please specify) :
_____

Skin
_____ Rashes
_____ Athletes foot
_____ Herpes / cold sore
_____ Epilepsy
_____ Allergies (please specify) :
_____

Digestive
_____ Irritable bowel syndrome
_____ Ulcers

Nervous System
_____ Shingles
_____ Numbness / tingling
_____ Pinched nerve
_____ Epilepsy

Reproductive
_____ Pregnant: Stage _____
_____ Ovarian / menstual problems
_____ Prostate

Circulatory
_____ Anemia
_____ Heart condition
_____ Phlebitis / Varicose veins
_____ Blood clots
_____ High / Low blood pressure
_____ Lymphedema
_____ Thrombosis / Embolism
_____ Swelling of hands / feet
_____ Bruise easily
_____ Light headed or dizziness
_____ Cold extremities

Musculoskeletal
_____ Bone or joint disease
_____ Tendonitis / Bursitis
_____ Arthritis / Gout
_____ Jaw pain (TMJ)
_____ Neck / Back pain:
Neck Mid Back Low Back
_____ Joint pain, stiffness, swelling
_____ Joint / muscle weakness
_____ Muscle cramps or pain

Other
_____ Cancer / tumors
_____ Bladder / kidney ailment
_____ Diabetes
_____ Chronic pain
_____ Sleep disorders
_____ Migraines / headaches
_____ Anxiety / stress syndrome
_____ Depression
_____ Hernia
_____ Other: _____
_____

Please list any medications you are currently taking for above conditions (include nonprescription) : _____

_____

Cancellation Policy

This office has a policy of charging a fee for missing an appointment or cancelling with less than 24 hours notice. The fee will be 50% of the regular charge for the missed session, regardless of discounts such as value package rates or senior discounts. Obviously, acute health problems and family crises are expected. Cancellations of convenience or last minute schedule conflicts will be your responsibility.

Bad Check Policy

There will be a $25.00 fee for all checks returned by your bank unpaid due to lack of sufficient funds.

Payment Agreement

I understand that payment in full is due at the time of service unless other arrangements have been made. I understand that any unpaid balances may be subject to an 18% annual interest rate, compounded at 1.5% each month. I agree to be held responsible for all attorney fees and court costs involved with the collection of this account.

Please take a moment to carefully read the following information and sign where indicated

I have read and fully understand the above policies. I agree to abide by the policies as stated.

I have read and discussed the medical information on this form. I understand that this work does not constitute a medical treatment but rather is a form of health promotion. I affirm that I have stated all of my known medical conditions and have answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that massage/bodywork may be contraindicated for specific medical conditions or symtoms. I understand a referral from my primary care provider may be required prior to services being provided. 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 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.

Client or Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____