MASSAGE INTAKE FORM

PERSONAL

First Name: _____

Last Name: _____

Address: _____

City: _____State: _____Zip: _____

Email _____

Occupation _____

Employer: _____

Reason for today's visit:

_____

_____

MASSAGE

Have you ever had a professional massage?

Yes No Date last: _____

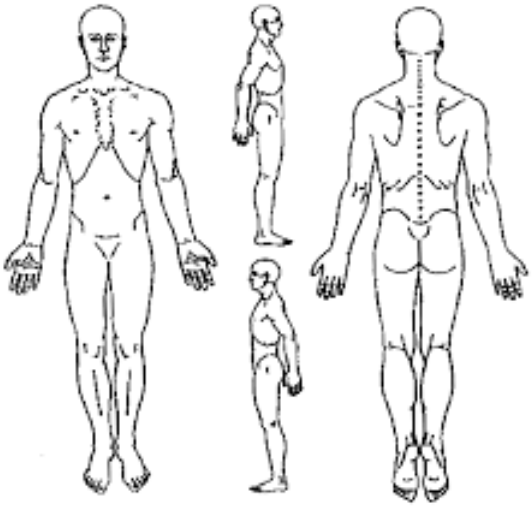
Any areas to avoid: _____

Are you pregnant? Yes No

Any allergies or hypersensitivities? Yes No

_____

Please place a check mark near any areas of pain.



EXPLAIN: _____

Referred by: _____

Date of birth: _____

Home #: _____

Cell #: _____

Emergency Contact: _____

Relationship: _____

Emergency number: _____

Physician's Name: _____

Physician's Phone #: _____

Goals for today's treatment: _____

_____

Type of Treatment: _____

Type of pressure:

- ○ Light
- ○ Medium
- ○ Deep

How would you rate your general health?

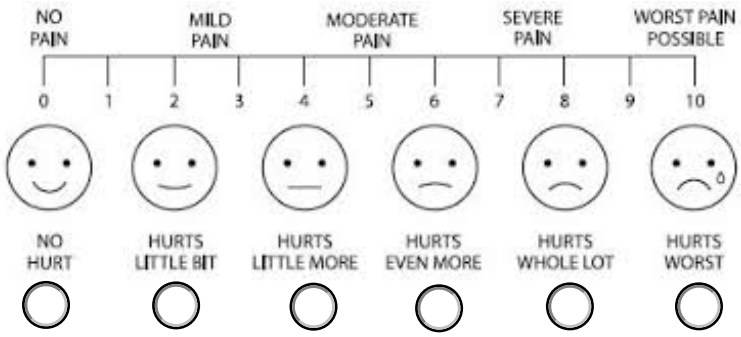
- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Do you suffer from chronic pain? ☐ Yes ☐ No

What makes it better? _____

What makes it worse? _____

PAIN (*Place a dot on the face that best represents your pain level***)**



MEDICAL

List current medications name and use:

_____
_____

List any major accidents or surgeries/date:

_____
_____

HEAD/NECK

- ☐ Headache/ Migraines
- ☐ Ringing in ears
- ☐ Vertigo/Dizziness
- ☐ Hearing loss
- ☐ Vision problems

RESPIRATORY

- ☐ Asthma
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Sinusitis
- ☐ Frequent colds
- ☐ Smoker #_____per day: _____
- ☐ COVID-19

  Date: _____

MUSCULOSKELETAL SYSTEM

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bursitis
- ☐ Tendonitis
- ☐ TMJ/Jaw pain
- ☐ Artificial joint/plates/pins/wires
- ☐ Family history of arthritis
- ☐ Strains or sprains

OTHER CONDITIONS

- ☐ Cancer
- ☐ Diabetes
- ☐ Anxiety
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Other_____

  _____

  _____

SKIN& INFECTIONS

- ☐ Hepatitis
- ☐ Herpes
- ☐ Lyme Disease
- ☐ Tuberculosis
- ☐ Eczema/psoriasis
- ☐ HIV/AIDS
- ☐ Infectious skin conditions

  Explain: _____

NERVOUS

- ☐ Sciatica
- ☐ Seizures
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Numbness/tingling
- ☐ Sensory loss or change

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Heart disease
- ☐ Stroke
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Phlebitis/varicose veins
- ☐ Chronic congestive heart failure
- ☐ Blood clots

REPRODUCTIVE

- ☐ Pregnant
- ☐ Given birth
- ☐ Gynecological problems
- ☐ Miscarriage

POLICY NOTIFICATION

We appreciate that you've chosen us for your massage and bodywork needs. TO provide the best sevice possible to our clients, we have implemented the following policies:

CANCELLATIONS

We respectfully ask that you provide us with 12-24-hour notice of any schedule changes or cancellation requests. Please understand that when you cancel or miss your appointment without providing adequate notice, we are often unable to fill that appointment time. This is an inconvenience to your therapist and also means our other clients miss the chance to receive the services they too may need. For this reason, you will be charged 50% of the service fee for the first missed session and 100% of the session fee for each session thereafter. We also reserve the right to require a credit card number to be given to book any future appointments so that appropriate fees may be charged if late cancellation does occur.

We understand that emergency situations can arise and illnesses do occur at inopportune times. If you are sick, have a fever, known infection or have experienced vomiting and or diarrhea within 24 hours prior to your appointment time, we request that you CANCEL your appointment. Inclement weather may also result in the need for late cancelations. We will do our best to give advanced notice if we are closing or need to reschedule and we ask that you do the same. Please, DO NOT risk your safety trying to make your appointment. Late cancellation due to emergencies, illnesses or inclement weather will generally not result in any missed session charges, but may be determined on a case-to-case basis.

LATE ARRIVAL

We request that you arrive 5-10 minutes prior to your appointment time to allow time to fill out any required paperwork as well as answer any intake questions your therapist may have. WE understand that issues can arise that may cause you to be late for your appointment. However, we ask that you call to inform us if this ever occurs so we can do our best to accommodate you. Appointment times are reserved for each client, so often times we cannot exceed that reserved time without making the next client late. For this reason, arriving after your appointment time may result in loss of time from your massage so that your session ends at the scheduled time. Full-service fees will be charged even when sessions are shortened due to late arrival. In return we will do our best to be on time, and if we are unable to do so we will add time to your session to make up for our late arrival or adjust the service charge accordingly.

INAPPROPRIATE BEHAVIOR

Massage therapy is for relaxation, medical and therapeutic purposes only. There is absolutely NO sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your session and a refusal of any and all services in the future. You will be charged the full-service fee regardless of the length of time of your session. Depending on the behavior exhibited, we may also file a report with the local authorities if necessary. Please treat your therapist with respect and dignity as you will be treated the same in return.

It is my choice to receive Massage Therapy. I am aware of the benefits and the risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that Massage Therapy is not a substitute for medical care, medical examination, or diagnosis. I have, to the best of my knowledge, stated all medical conditions that I am aware of and will inform my practitioner of any and all changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared with various care providers involved in my care and treatment.

Treatments may be covered by extended healthcare plans. I understand that it is my responsibility to confirm the exact details of my coverage. I also understand that I am responsible for all payments which are due at the time of service.

By signing below, you agree to abide by these terms and policies.

_____

CLIENT SIGNATURE **DATE**

_____

PRACTIONER SIGNATURE **DATE**

_____

FOR OFFICIAL USE ONLY NOTES: