Client Intake Form - Therapeutic Massage

Personal Information:

Name _____ Phone (Day)_____ Phone (Eve) _____
Address_____

City/State/ZiP _____

email _____ Date of Birth_____ Occupation _____

Emergency Contact Phone _____

The following Information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No

   For Cranio Sacral Clients – Have you had a Cranio Sacral Therapy session before? Yes No

   If yes, how often do you receive massage therapy or Cranio Sacral Therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe_____

7. Do you perform any repetitive movement in your work, sports. or hobby? Yes No

   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

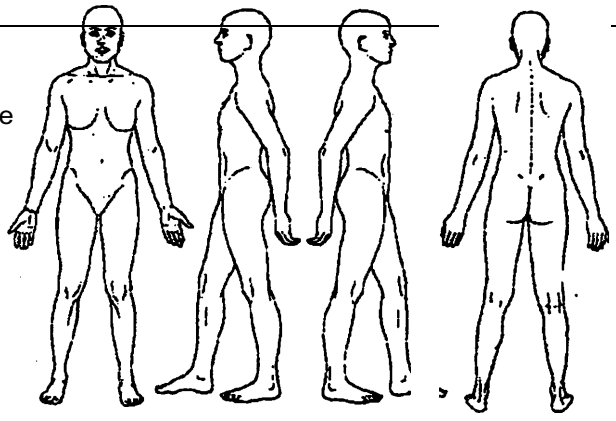
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



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Medical History

In order to plan a massage session that is safe and effective,
I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
    If yes. please explain _____
12. Do you see a chiropractor? Yes No If yes, how often? _____
13. Are you currently taking any medication? Yes No
    If yes. please list _____
14. Please check: any condition listed below that applies to you:

( ) contagious skin condition	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
(} recent accident or injury	(} osteoporosis
(} recent fracture	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer
( ) sprains/strains	( ) diabetes
(} current fever	( ) decreased sensation
(} swollen glands	( ) back/neck: problems
( ) allergies/sensitivity	( ) Fibromyalgia
( ) heart condition	( ) TMJ
( ) high or low blood pressure	(} carpal tunnel syndrome
( ) circulatory disorder	( ) tennis elbow
(} varicose veins	( ) pregnancy If yes. how many months?
( ) atherosclerosis	

Please explain any condition that you have marked above _____

_____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

I. _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation, relief of muscular tension, and to release restrictions found within the soft tissues. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure, strokes, and/or techniques may be adjusted to my level of comfort. I further understand that massage and 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 that I am aware of. I understand that massage therapists 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 and/or 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 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.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____