Massage Intake Form

Personal Information

(existing patients only need to fill in name and DOB)

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Preferred Phone _____ (Home/Cell/Work) Primary Physician _____

Email _____ How did you hear about us? _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

Medical Information

Are you taking any medications? __Yes __No

If yes, please list name and use: _____

_____

Are you currently pregnant? __Yes __No

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? __Yes __No

If yes, please explain _____

What makes it better? _____

_____

What makes it worst?_____

_____

Have you had any orthopedic injuries? __Yes __No

If yes, please list: _____

_____

Please indicate any of the following that apply to you.

__ Cancer
__ Headaches/Migraines
__ Arthritis
__ Diabetes
__ Joint Replacement(s)
__ High/Low Blood Pressure
__ Neuropathy
__ Fibromyalgia
__ Stroke
__ Heart Attack
__ Kidney Dysfunction
__ Blood Clots
__ Numbness
__ Sprains or Strains

Explain any conditions marked above:

_____

_____

_____

_____

_____

_____

Massage Information

Have you had a professional massage before?

__Yes __No

If yes, when was your last massage: _____

Frequency of massages? _____

What are your goals for this treatment session?

_____

_____

What type of massage are you seeking?

__ Relaxation __Therapeutic/Deep Tissue

Other:_____

What pressure do you prefer?

__Light __ Medium __ Deep **($10 extra)**

Do you have any allergies or sensitivities? __Yes __No

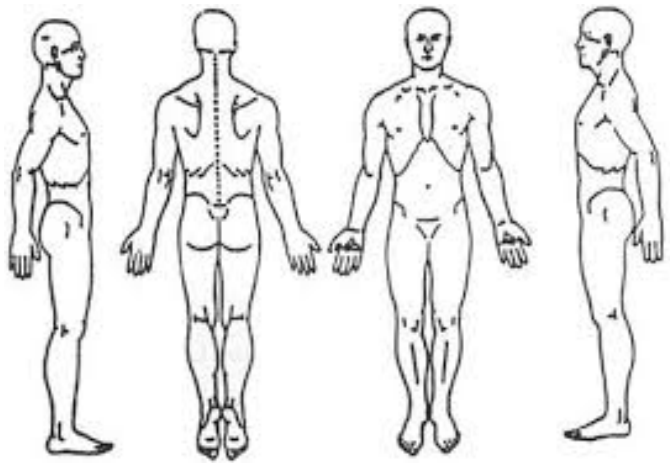
If yes, please explain: _____

Are there any areas (feet, face, abdomen, etc.) that you do not want massaged? __Yes __No

If yes, please list: _____

_____

Please circle any areas of discomfort



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Policies

Cancellations

A 24 hour notice is required to cancel or reschedule your massage appointment. If you are unable to keep your appointment for any reason please call the office to reschedule. If we do not receive a minimum of 24 hours notice for any cancelled or rescheduled appointments, you may be charged the full amount for your visit._____ (patient initials)

Our massage therapists are committed to providing all their patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being treated which also directly results in lost revenue for the massage therapist. _____ (patient initials)

Gift Certificates and promotional offers, including complimentary or free massage services, are subject to the same policy. _____ (patient initials)

Session

Each session ends 2-5 minutes early in order for each client to have time to slowly get up and dress after their session. _____ (patient initials)

If you are late for your appointment, your session will still end at the scheduled time and full payment is due. _____ (patient initials)

Rights

Patients have the right to stop treatment at anytime for any reason. _____ (patient initials)

Massage Therapists have the right to refuse treatment to anyone who has a medical condition that is unsafe for massage therapy, or anyone that has an outstanding balance. _____ (patient initials)

I understand that massage therapy is not a substitute for medical care. Massage therapists cannot prescribe, treat, or give medical diagnosis and nothing said during the session should be considered as such. I affirm that i have listed all medical conditions and answered all questions honestly. I agree to inform the therapist of any experience of pain during the session. I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part. I agree to hold harmless the establishment, all management, including volunteers, from and against any and all claims.

I have read and agree with all policies, including the Cancellation Policy.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____