UNITY
WELLNESS

MASSAGE THERAPY INTAKE

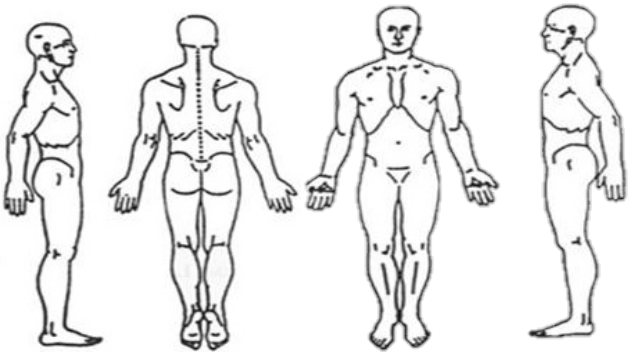
Name: _____ Date of Birth: _____

Occupation: _____

Reason for visit: _____

Do you have any allergies/sensitivities to lotions or oils? ☐ No ☐ Yes: _____

Mark all areas that cause discomfort:



Please check the words that describe your pain/symptoms:

☐ Sharp ☐ Dull/Aching ☐ Throbbing

☐ Radiating, to: _____

☐ Numb ☐ Tingling ☐ Burning

☐ Shooting, to: _____

HEALTH HISTORY

Check all that apply:

☐ Anxiety	☐ Arthritis	☐ Autoimmune Disease	☐ Blood Clots
☐ Bruises Easily	☐ Cancer	☐ Carpal Tunnel Syndrome	☐ Circulatory Disease
☐ Decreased Sensation	☐ Diabetes	☐ Epilepsy	☐ Fever
☐ Heart Disease	☐ Headaches	☐ High Blood Pressure	☐ HIV
☐ Jaw Problems	☐ Migraines	☐ Nausea	☐ Numbness/Tingling
☐ Open Sores/Wounds	☐ Osteoporosis	☐ Phlebitis	☐ Pregnant
☐ Respiratory Problems	☐ Sinus Problems	☐ Skin Conditions	☐ Sprain/Strain
☐ Stress	☐ Stroke	☐ Swollen Glands	☐ Varicose Veins
☐ Whiplash	☐ Surgeries, _____		

Other: _____

List all medications and supplements you are taking (including birth control pills): _____

_____

Provide any other information that may assist the therapist in providing you with a massage that fits your needs:

_____

_____

INFORMED CONSENT

Please take a moment to carefully read the following and sign where indicated.
The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Since massage is contraindicated for some serious medical conditions, it may be necessary to obtain a doctor's release or prescription before beginning massage. I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, and treatment, and that I should see a medical or chiropractic physician or other healthcare specialist. I agree to update the massage therapist in regards to changes in my health and understand that there shall be no liability on the therapist should I neglect to do so.

I understand that:

- The relationship between the client and the massage therapist is a confidential one and that all information provided to the therapist is to be kept confidential
- My body will be properly draped at all times for comfort, security, and warmth
- The massage is solely for the purpose of therapeutic massage and that the massage therapist has the right to be free from any unwanted, harmful, offensive, behaviour and/or physical contact. This will result in the termination of the session
- I will inform the therapist of any discomfort, so that the application of pressure or stroke may be adjusted to my level of comfort
- The benefits of massage and discomfort that I may feel have been explained
- Should I have to cancel or change my appointment for any reason, I agree to give the therapist 24 hours notice or otherwise be billed 50% of the cost of my missed appointment

_____ _____

Print Name Client/Guardian Signature

_____ _____

Date Therapist Signature