Massage Therapy Intake Form

Name_____ Date_____

Address_____
Street City State Zip

Date of Birth_____ Contact # _____ Email_____

Emergency Contact _____
Name Relationship Number

Are you presently taking any medication? _____Yes _____No

Please Explain:

_____

_____

Have you had massages in the past? _____Yes _____No

Have you had a recent major surgical procedure or injury? ____ Yes ____ No

What goals are you hoping to achieve by receiving this massage? (ie increased range of motion, decreased pain, relaxation, etc.) Please Explain:

_____

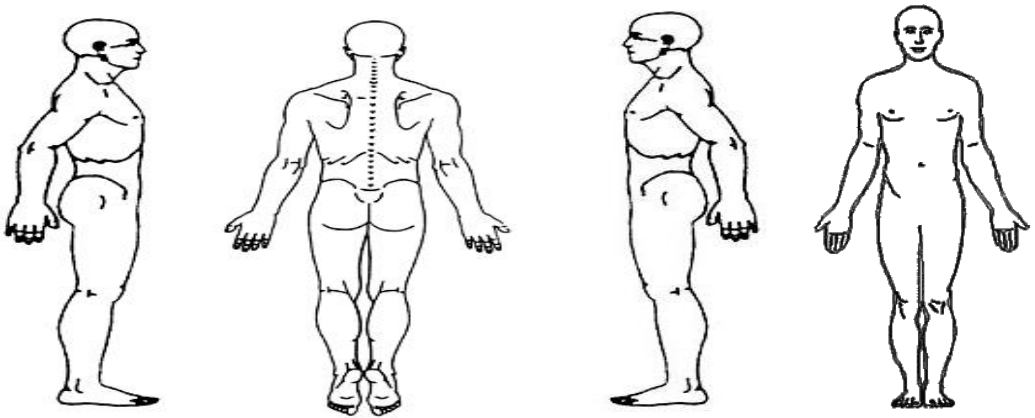
_____

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?____ Yes ____No

Please mark with an **"X"** where you are experiencing any pain or discomfort.

Please Explain:

Please circle your stress level:
Low 1 2 3 4 5 High



Are you allergic to any Lotions or Oils? ____ Yes ____ No
Please Explain:_____

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other:_____

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
Asthma
High blood pressure
Low blood pressure
Other:_____

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Colitis
Other:_____

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other:_____

Reproductive System

Pregnancy

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophelia

Other

Loss of Appetite
Depression
Difficulty concentrating
Hearing Impaired
Visually Impaired
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer
Tuberculosis
Other:_____

I understand that a massage Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the massage Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes in my status.

CONSENT FOR THERAPY & WAIVER OF LIABILITY

The undersigned ("Client") hereby freely consents to receipt of massage services from:

_____

Licensed Massage Therapist's Name

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information, and a written referral from Client's primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manually therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.
2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.
3. Client hereby assumes fully responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist , to the fullest extent allowed by law.
4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist
5. **Cancellation Policy:** Massages must be cancelled by 6pm the previous night. There will be a $50 charge, per patient, per occurrence, due immediately, prior to any further appointments being scheduled for ALL missed or late-cancel (cancelled later than 6pm the previous night) massage appointments.

_____ _____

Client or Parent Signature **Client or Parent Printed Name**

_____

Date

_____ _____

Massage Therapist Signature Massage Therapist Printed Name

_____

Date