Client Intake and Informed Consent - Massage Therapy

Name ____ **Birth Date** _______________________

General

- Please describe your:
  - Occupation ____
  - Hobbies/Sports/Activities ____
  - Sleep patterns ____
- List any surgeries in the last 5 years ____
- Have you had a professional massage before? Yes ( ) No ( )
- Do you have any difficulty lying on your front, back or side? Yes ( ) No ( )

  If yes, please explain ____
- Do you have any allergies or sensitivities to oils, lotions or ointments? Yes ( ) No ( )

  If yes, please explain ____
- Are you wearing contact lenses? ( ) dentures? ( ) a hearing aid ? ( )
- How much time do you spend seated each day (computer, driving, at home)? ________
- Does your lifestyle include regular physical activity? Yes ( ) No ( )

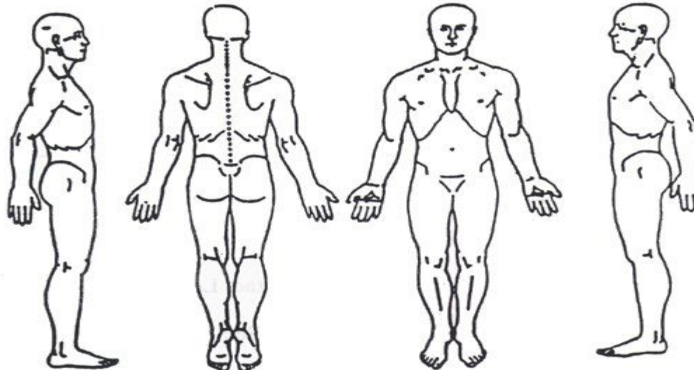
  If yes, please describe ____
- Are you currently under medical supervision? Yes ( ) No ( )

  If yes, please explain ____
- Are you receiving treatment from any other health professional?

  Physician ( ) Chiropractor ( ) Physical Therapist ( ) Acupuncturist ( )

  Other____

Please indicate any areas where you are experiencing soreness, discomfort or other problems:



Health History

Please indicate conditions currently or recently experienced. List location where relevant.

( ) contagious skin conditions
( ) open sores or wounds
( ) deep vein thrombosis/blood clots
( ) recent fracture
( ) artificial joint ______________________
( ) sprains/strains ______________________
( ) current fever
( ) high or low blood pressure _______________
( ) circulatory disorder _____________________
( ) varicose veins
( ) pregnancy – due date _____________________
( ) phlebitis
( ) recent accident or injury clots
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) TMJ
( ) atherosclerosis
( ) scoliosis

Please explain any condition(s) you have marked above:

____

____

Please list any motor vehicle accidents, the date(s), and any whiplash or other injuries sustained:

____

Please list any current medications and what they are for:

____

____

Is there anything else about your health history that you think your massage therapist should know in order to better treat you?

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____

Informed Consent for Treatment

I, ___________________________________(print patient name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 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.

Client (Parent/Guardian) Signature ___________________________ Date ____________________