CLIENT INTAKE FORM

PLEASE COMPLETE THE ENTIRE FORM (FRONT AND BACK).

PERSONAL INFORMATION: Today's Date: _____

Name: _____ Phone (Home): _____ Phone (Cell): _____

Address: _____

City: _____ State: _____Zip Code: _____

Email address (needed to send appointment confirmations): _____

Date of Birth: _____ Occupation: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

THE FOLLOWING INFORMATION WILL BE USED TO HELP PLAN A SAFE AND EFFECTIVE MASSAGE SESSION. PLEASE ANSWER THE QUESTIONS BELOW COMPLETELY AND HONESTLY.

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

   If yes how often do you receive a massage session? _____

2. Do you have any difficulty lying on your stomach, 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? Yes No Dentures? Yes No Hearing aid? Yes No

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

   If yes, please explain _____

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

   If yes, please explain _____

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

   If yes, please explain _____

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

   If yes, please identify _____

   On a scale of 1-10 (with 1 being the lowest and 10 being the highest where is your discomfort/ pain at currently.

   1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10 ( )

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

    If yes, please explain _____

11. Please list any specific area that you would like the massage therapist to concentrate on during the session.

_____

_____

MEDICAL HISTORY

IN ORDER TO PLAN A MASSAGE SESSION THAT IS SAFE AND EFFECTIVE, I NEED SOME GENERAL INFORMATION ABOUT YOUR MEDICAL HISTORY.

12. Are you currently under medical supervision? Yes No

If yes, please explain _____

Doctor's Name _____ Phone: _____

13. Do you see a chiropractor? Yes No If yes, how often? _____

14. Are you currently taking any medications? Yes No

If yes, please list_____

15. Please check all conditions listed below that apply to you

( ) contagious skin condition	( ) phlebitis	( ) sexually transmitted disease(s)
( ) open sores or wounds	( ) deep vein thrombosis / blood clots	( ) HIV/ AIDS
( ) 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	( ) artherosclerosis
( ) depression/ anxiety	( ) pregnancy If so, how many months? _____	

Please explain any condition that you have marked above:

_____

_____

16. Is there anything else about your health history that you would think would be useful for your massage therapist 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 17 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 17.

I, _____ (print 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 the session, I will immediately inform the therapist so that the pressure and / or strokes may be adjusted to my comfort level. I further understand that massage is not 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. I understand that I am responsible for all charges for the service(s) provided. I understand that any sexual remarks or advances will result in termination of the session and will leave me liable for payment of the scheduled session.

Signature of Client_____ Date: _____

Signature of Massage Therapist _____ Date: _____

Massage Policies

CANCELLATION POLICY: Your scheduled appointment time has been exclusively reserved for you. If you are unable to keep your appointment, please give **24-hour** notice or you will be charged the **FULL** amount of your scheduled massage. Cancellations with less than 24-hour notice are very difficult to fill. By giving last minute notice you prevent someone else from being able to schedule in that time slot. I understand that emergencies and unanticipated events occur in everyone's life so I will take this into consideration upon your cancellation.

LATE ARRIVAL POLICY: Late arrivals will not receive an extension of scheduled appointments. In special cases, and when my schedule allows, I may be able to accommodate a partial or full appointment. This will be at my discretion and only with proper, advanced notification of your late arrival. The **FULL** price of your scheduled session be charged.

NO SHOW POLICY: If you fail to show for your scheduled appointment you will be charged the **FULL** price of your scheduled session, and you may be asked to pre-pay for future services.

ZERO TOLERANCE POLICY: Any sexual remarks or advances will result in immediate termination of your scheduled appointment. You will be charged the **FULL** price of your scheduled session. You will not be permitted to return for any future appointments.

By signing below, you acknowledge that you have read and understand the Massage Policies for Nourishing Massage as described above.

Thank you for your understanding and cooperation.

Printed Name: _____

Signature: _____

Date: _____